END OF THE UNFPA 6th COUNTRY PROGRAMME EVALUATION IN MALAWI

FINAL REPORT

Submitted to:

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Submitted by:

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ACKNOWLEDGEMENTS</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACRONYMS</td>
<td>V</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>IX</td>
</tr>
</tbody>
</table>

## 1 INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION
1.2 BACKGROUND
1.3 PURPOSE OF THE EVALUATION
1.4 Specific Tasks
1.5 Key Issues in the Evaluation

## 2 METHODOLOGICAL APPROACH

2.1 Literature Review
2.2 Data Collection Instrument Development
2.3 Briefing Meetings
2.4 Consultation and In-depth Interviews
2.5 Sampling
2.5.1 Summary of Sampled Institutions
2.6 Data Analysis, Interpretation and Reporting

## 3 PROGRAMME RELEVANCE, APPROPRIATENESS AND EFFICIENCY

3.1 Programme Relevance and Appropriateness
3.2 Programme Efficiency
3.3 Institutional Arrangements
3.3.1 UNFPA Country Office
3.3.2 GoM Coordination Mechanism
3.3.3 Implementing Partners and Partnerships
3.3.4 Issues in Programme Design and Implementation Strategy

## 4 FINDINGS, DISCUSSIONS AND INTERPRETATIONS

4.1 Sexual Reproductive Health and HIV Prevention
4.1.1 Increased Availability of Quality, Integrated, Gender-Sensitive Sexual and Reproductive Health and HIV and AIDS Services
4.1.2 Increased Availability of Life Skills Education for Young People in and out of School
4.2 Population and Development
### 4.2.1 Increased National Capacity to Generate, Analyse and Disseminate Gender-Disaggregated Data

Page 28

### 4.2.2 Increased Availability of a National Gender-Disaggregated Database for Monitoring and Evaluation

Page 32

### 4.3 Gender

Page 33

#### 4.3.1 Strengthening the Legislative Framework for Gender Equality and Equity

Page 34

#### 4.3.2 Capacity in Gender Analysis, Mainstreaming and Budgeting Strengthened

Page 39

### 5 Monitoring and Evaluation

Page 42

### 6 Lessons Learned

Page 43

### 7 Programme Impact

Page 45

#### 7.1 Overall

Page 45

#### 7.2 RH and HIV Prevention

Page 45

#### 7.3 Population and Development

Page 46

#### 7.4 Gender

Page 47

### 8 Sustainability

Page 48

### 9 General Conclusions and Recommendations

Page 51

#### 9.1 Conclusions

Page 51

#### 9.2 Recommendations

Page 51

##### 9.2.1 CO and IPs

Page 51

##### 9.2.2 Programme Management

Page 53

##### 9.2.3 Financial Management

Page 53

##### 9.2.4 Programme Performance

Page 54

### 10 Appendices

Page 58

#### 10.1 References

Page 58

#### 10.2 Data Collection Instruments

Page 60

#### 10.3 Terms of Reference

Page 69
ACKNOWLEDGEMENTS

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ACRONYMS

ADB  African Development Bank
AIDS  Acquired Immune Deficiency Syndrome
ANC  Antenatal Care
ART  Anti Retroviral Treatment
BEmONC  Basic Emergency Obstetric and Neonatal care
BLM  Banja La Mtsogolo
CAG  Community Action Group
CARMMA  Campaign on Accelerated Reduction of Maternal Mortality
CBC  Community Based Care
CBO  Community Based Organisation
CBDA  Community Based Distribution Agent
CO  Country Office
COWLHA  Coalition of Women Living with HIV and AIDS
CP  Country Program
CPAP  Country Programme Action Plan
CPR  Contraceptive Prevalence Rate
CS  Commodity Security
CSO  Civil Society Organisation
CVSU  Community Victim Support Unit
DEC  District Executive Committee
DFID  Department for International Development
DHMT  District Health Management Team
DHO  District Health Office
DHS  Demographic and Health Survey
DMPA  Depo Provera
DRCS  Dickens Robert Consulting Services
EU  European Union
FBO  Faith Based Organisation
FGD  Focus Group Discussions
FP  Family Planning
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>FPAM</td>
<td>Family Planning Association of Malawi</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
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<td>GIS</td>
<td>Geographical Information System</td>
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<td>GoM</td>
<td>Government of Malawi</td>
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<td>GTZ</td>
<td>Germany Development Cooperation</td>
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<td>HIV</td>
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<td>HIV Testing and Counselling</td>
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</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IDIs</td>
<td>In-Depth Interviews</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>IP</td>
<td>Implementing Partner</td>
</tr>
<tr>
<td>KCN</td>
<td>Kamuzu College of Nursing</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MAGGA</td>
<td>Malawi Girl Guides Association</td>
</tr>
<tr>
<td>MANASO</td>
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</tr>
<tr>
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<td>Malawi Socio Economic Database</td>
</tr>
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<td>Malawi Broadcasting Corporation</td>
</tr>
<tr>
<td>MBTS</td>
<td>Malawi Blood Transfusion Services</td>
</tr>
<tr>
<td>MD</td>
<td>Maternal Death</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
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<tr>
<td>MHEN</td>
<td>Malawi Health Equity Network</td>
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<td>Malawi Interfaith AIDS Association</td>
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<td>Malawi Law Commission</td>
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<td>MMR</td>
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<td>MNH</td>
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<td>MoDPC</td>
<td>Ministry of Development Planning and Cooperation</td>
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<td>MoGCCD</td>
<td>Ministry of Gender, Children and Community Development</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>Acronym</td>
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<td>NAC</td>
<td>National AIDS Commission</td>
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<td>NAF</td>
<td>National Action Framework</td>
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<td>NGOGCN</td>
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<tr>
<td>NPA</td>
<td>National Plan of Action</td>
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<tr>
<td>NRGBV</td>
<td>National Response to Combat Gender Based Violence</td>
</tr>
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<td>NSA</td>
<td>Non-State Actors</td>
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<td>National Statistical Office</td>
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<td>National Youth Council of Malawi</td>
</tr>
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<td>OVC</td>
<td>Orphaned and Vulnerable Children</td>
</tr>
<tr>
<td>P &amp; D</td>
<td>Population and Development</td>
</tr>
<tr>
<td>PDVA</td>
<td>Prevention of Domestic Violence Act</td>
</tr>
<tr>
<td>PHC</td>
<td>Population Housing Census</td>
</tr>
<tr>
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<td>People Living with HIV</td>
</tr>
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<td>Prevention of Mother to Child Transmission</td>
</tr>
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<td>RHU</td>
<td>Reproductive Health Unit</td>
</tr>
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<td>SADC</td>
<td>Southern Africa Development Community</td>
</tr>
<tr>
<td>SMC</td>
<td>School Management Committee</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
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<td>SWAP</td>
<td>Sector-Wide Approach</td>
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<td>TA</td>
<td>Traditional Authority</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<td>TWG</td>
<td>Technical Working Group</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme for AIDS</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VHC</td>
<td>Village Health Committee</td>
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<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>YFHS</td>
<td>Youth Friendly Health Services</td>
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<tr>
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<td>Youth Gender Sector Working Group</td>
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EXECUTIVE SUMMARY

This is the final evaluation report for the 6th Country Programme of the United Nations Population Fund (UNFPA). The report is organised to present the background, methodology, results, conclusions and recommendations. The government of Malawi and UNFPA partnership in the 6th Country Programme and Country Programme Action Plan (CPAP) is for 4 years 2008-2011. The programme focuses on reproductive health and HIV prevention, gender, and population and development.

The goal of the 6th Country Programme is to contribute improving quality of life for the people of Malawi by improving reproductive health status, preventing HIV, increasing gender equality and empowering women, and creating favourable interactions between population dynamics and development. The programme responds to the goals of the United Nations Development Assistance Framework (UNDAF), the Malawi Growth and Development Strategy (MGDS) and the International Conference on Population and Development (ICPD) Programme of Action. Programme components include: reproductive health and HIV prevention, gender, and population and development. These components promote advocacy by taking a rights-based and culturally-sensitive approach.

The expected outcomes of the 6th Country Programme are:

- Increased equitable access to reproductive health and HIV prevention services;
- Improved national capacity to use population data for policy and programme formulation, management and monitoring; and
- Enhanced gender equality and empowerment of women by 2011.

In 2008, a mid-term evaluation was completed for the 6th CP. It was concluded that UNFPA had made great progress toward achieving the expected CP outcomes as evidenced by the launch of CARMMA, a shift in parliamentary representation by women from 14% to 22% as a result of the 50/50 campaign, high interest in and utilisation of HTC, and a population and housing census which not only allows for the equitable distribution of resources, but represents a tremendous achievement in the history of the country.

This evaluation employed both qualitative and quantitative methods, and was designed to involve UNFPA staff, their implementation partners and various beneficiaries at hospitals and clinics, as well as those in communities and villages. In conducting the evaluation, data collection instruments were developed consistent with various data collection methods. We developed customised guidelines/checklists which were utilised during either FGDs or KII that were conducted with key relevant community members in target outcome areas. A total of 15 partner organisations were included in the interview sample. In each district, we conducted interviews in three district hospitals and in one health centre under each of the sampled district hospitals. We interviewed medical assistants and community members at community health centres.

We present our results consistent with CPAP outputs. These outputs are: 1) increase the availability of quality, integrated, gender-sensitive sexual and reproductive health and HIV/AIDS services; 2) increase the availability of life skills education for young people both in and out of school; 3) increase the national capacity to generate, analyse and disseminate gender-disaggregated data; 4) increase the availability of a national gender-disaggregated database for
monitoring and evaluation; 5) strengthen the legislative framework for gender equality and equity; and 6) strengthen capacity in gender analysis, mainstreaming and budgeting. Outputs 1 and 2 correspond to the UNFPA priority on sexual reproductive health and HIV prevention; outputs 3 and 4 correspond to the priority on population and development; and outputs 5 and 6 correspond to the priority on gender. Thus, we organise our findings according to the 3 UNFPA priority areas and the strategies employed within the six CPAP outputs.

Our findings show that the 6th CP made the following contributions to reproductive health and HIV prevention:

- Reduced maternal mortality by increasing the number of deliveries by skilled health attendants and reorienting TBAs toward new roles.
- Increased use of antenatal care services due to community interventions focused on MNH and the formation of community-level committees on safe motherhood.
- Increased skills of health attendants by providing training on obstetric life saving skills and basic infection prevention equipment.
- Increased use of family planning techniques by training providers at the district, health centre and community levels.
- Reduced the fertility rate through various family planning interventions at both the facility and community levels.

Our findings show that 6th CP made the following contributions to population and development:

- Increased capacity among various professionals within the GoM, enabling them to plan and appropriately target communities for development interventions.
- Facilitated equal access to higher education by providing the government with current population information which is used for public university admission decisions, ensuring that the eventual benefits will be appropriately distributed to all parts of the country.
- The upcoming population policy, which has been made possible largely due to support from the 6th CP, is anticipated to further enable informed decisions in development planning, while increasing dialogue around population growth and the resulting strain on the country’s resources, which further exacerbates poverty, deaths and general suffering of the population.
- Due to the availability of population data, institutions such as the National Local Government Finance Committee are now able to equitably distribute financial resources for development of all districts in Malawi.

The 6th Country Programme has also made the following contributions to gender equality and the empowerment of women as follows:

- Reduced the number of school drop-outs through efforts related to youth RH and HIV prevention both in school and out; those out of school have been encouraged to re-enrol.
- Reduction and modification of harmful sexual cultural practices which affect both women and girls, like early marriages and kupimbira (offering a female child in marriage as a debt payment, or pre-arranging a marriage in exchange for economic gains), chokolo (inheriting a woman after the death of a brother or an uncle) and chijula nthowa (sleeping with a girl soon after she reaches puberty).

- Increased care for OVCs and other VGs by establishing CBCs through the District Assemblies where OVCs and other children are supported with education and food. The communities also assist the OVCs and other VGs by providing them with other needs such as blankets, food and clothes, which in turn reduces stigma and discrimination.

- Increased political representation of women in the Malawi Parliament and other decision making positions in various sectors of the economy, thereby increasing the potential for prioritising issues affecting women.

- Reduced incidence of GBV in one UNFPA-supported project due to increased awareness of women and the communities as a whole to report such acts.

- Facilitated the availability of appropriate legislation which provides for the protection and respect of human rights of the people of Malawi, especially vulnerable populations.

We conclude that the 6th CP made significant achievements in addressing the goals of UNFPA consistent with CPAP for the citizens of Malawi. However, several challenges remain in each of the priority areas. We therefore recommend that the 7th CP be developed using baseline data which each partner institution should submit to UNFPA at least six months before beginning its program. We also recommend that in the future, at least eight weeks should be allowed for evaluation in order to accommodate follow-up visits for clarification purposes. Unfortunately, this was not possible in this evaluation due to time limitations.
I INTRODUCTION AND BACKGROUND

1.1 Introduction


The goal of the 6th Country Programme is improve quality of life for the people of Malawi by improving reproductive health status, preventing HIV, increasing gender equality and empowering women, and facilitating favourable interactions between population dynamics and development. The programme responds to the goals of the United Nations Development Assistance Framework (UNDAF), the Malawi Growth and Development Strategy (MGDS), and the International Conference on Population and Development (ICPD) Programme of Action. Programme components include: reproductive health and HIV prevention, gender, and population and development. These components promote advocacy through a rights–based, culturally sensitive approach.

The expected outcomes on the 6th Country Programme are:

- Increased equitable access to reproductive health and HIV prevention services;
- Improved national capacity to use population data for policy and programme formulation, management and monitoring; and
- Enhanced gender equality and empowerment of women by 2011.

The CP outcomes directly contribute to the achievement of specific UNDAF objectives, and were assessed based on the achievement of set targets for each component area. Several outputs and strategies as specified in the CPAP were proposed for the realisation of the Country Programme outcomes.

UNFPA Malawi collaborates with the Government of Malawi through the Ministries of Finance, Development Planning and Cooperation, Health, Education, Gender, Women and Child Development, Youth Development and Sports, the National Statistical Office, National AIDS Commission (NAC), The Law Commission and the University of Malawi. UNFPA is also working with Civil Society Organisations including Faith Based Organisations. The NGOs that UNFPA supports include: Banja La Mtso (BLM), Family Planning Association of Malawi (FPAM), NGO Gender Coordination Network, Malawi Interfaith AIDS Association (MIIA), Coalition of Women Living with HIV and AIDS (COWLHA), Enumerical Counselling Centre, Malawi Health Equity Network, and Malawi Girl Guides Association (MAGGA). These organisations function as strategic partners for achieving the UNDAF and Country Programme outcomes.

UNFPA is evaluating the 6th Country Programme in its penultimate year so findings and recommendations can inform the development of the 7th Country Programme in 2011.
1.2 Background

UNFPA facilitated the successful completion of the national census for Malawi. The 2008 Population and Housing Census provides substantial data critical to monitoring MDGs and ICPD goals. Other initiatives of national significance included: 1) supported the government/NSO in the implementation of a financial resource mobilisation strategy for the 2008 PHC along with other donors including the DFID, GTZ, the Irish government, the EU and the ADB; 2) supported two sensitisation and advocacy forums for the Health and Population Committee of Parliament and the media in preparation for the 2009 MDHs; and 3) provided a teaching and learning laboratory as a viable facility which has enhanced research and data analysis, and served as a critical resource for demography students.

In 2008, a mid-term evaluation was completed for the 6th CP. It was concluded that UNFPA had made great progress toward achieving the expected CP outcomes as evidenced by the launch of CARMMA, a shift in parliamentary representation by women from 14% to 22% as a result of the 50/50 campaign, high interest in and utilisation of HTC, and a population and housing census which not only allows for the equitable distribution of resources, but represents a tremendous achievement in the history of the country.

The report also noted an increase in the number of men, women, girls and boys engaged in rolling out SRH, gender equality, and HIV prevention programs. Inequalities were noticeably bridged by increasing access to information on life alternatives, and greatly improving access to such programs.

Project management at the national, district and community levels were significantly improved as evidenced by strong committees and support groups with adequate membership, proper basic record keeping and precise reports, up-to-date statistics and trained volunteers facilitating community work. Strong linkages and referral systems emerged and developed at the district and community levels, where communities were empowered to demand fulfilment of their rights from appropriate service providers.

Increased strategic engagement by implementation partners enhanced the conceptualisation of issues, as well as intervention planning, implementation and reporting. This increased the levels of critical thinking pervasively, which allowed more skills to be developed along the way.

1.3 Purpose of the Evaluation

The focus of this final evaluation is to assess the performance and impact of the 6th Country Programme, paying particular attention to reproductive health and HIV prevention, gender, and population and development. The primary goals are to determine the relevance, effectiveness, efficiency, sustainability, and impact of these programmes in the light of the objectives specified in the CP. As part of this final report, a set of recommendations are presented that could serve as a foundation for the 7th Country Programme to address any adverse impacts or to optimise Programme benefits.

1.4 Specific Tasks

The specific objectives of the assignment are to assess:
• How the 6th Country Programme has contributed to the achievement of UNDAF, MGDS outcomes and the MDGs;
• The effectiveness of the 6th Country Programme at improving the reproductive health of men, women and young people in Malawi;
• The effectiveness of the 6th Country Programme at improving the availability of quality, sex-disaggregated data and increasing its use in development;
• The contribution of the 6th Country Programme towards the national response to HIV prevention;
• The effectiveness of the 6th Country Programme at curbing gender-based violence (GBV) and enhancing the empowerment of women; and
• The sustainability of the 6th Country Programme’s interventions.

1.5 Key Issues in the Evaluation

The evaluation focuses on the key measures used by the UNFPA Country Programme to determine the whether or not established goals and objectives were achieved. These are effectiveness, efficiency, relevance, sustainability and impact.

Effectiveness

Effectiveness is the extent to which an intervention’s objectives were achieved, or are expected to be achieved, taking into account their relative importance. More specifically, effectiveness is the relationship between an intervention’s outputs (i.e., its products or services), its immediate results, and its outcomes (i.e., the intended benefits for a particular target group of beneficiaries). As a result, we pose the following questions:

• To what extent were objectives, expected results and their expected targets met under the 6th Country Programme?
• What key factors contributed towards the achievement of these objectives and expected results, and what factors hindered this?
• How effectively did the programme staff members coordinate with other relevant agencies (e.g., government, UN Agencies, NGOs or community-based organisations) in the programme areas?
• To what extent was information documented and used to modify the programme?
• Which promising practices can be expanded in the next Country Programme?
• To what extent was the designed M&E method able to track the outputs of the programme?
• Did the CP implementation adhere to the programme management and operational procedures stipulated in the CPAP, including execution arrangements, coordination, monitoring and human resources?
Efficiency

Efficiency refers to how well resources were used to ensure maximum achievement of the programme's goals. As a result, we ask the following questions:

- How many resources were allocated for the implementation of UNFPA-funded interventions, and were all such resources made available to meet the programme's goals?
- How adequate were those resources, and were planned outcomes attained with them?
- Were resources provided in a timely fashion, and if not, to what extent did that affect the intervention implementation and the achievement of outputs and outcomes?
- How effective was the resource delivery system?
- What financial management and accountability systems were in place, and how did these contribute to the prudent management of resources?
- What types of technical support were received from UNFPA over the course of the programme, and how was the programme best supported technically, in relation to financial management?
- What are the costs for implementing comparable interventions to those undertaken for UNFPA-funded programs?
- Apart from UNFPA resources, what other locally-generated resources were used for implementing the interventions?
- What limitations are there to implementing UNFPA-funded Programmes on a broader scale?

Relevance

Relevance is the extent to which the 6th CP goals and objectives were consistent with the country's requirements in terms of reproductive health and HIV/AIDS, national capacity to generate and use population data for policy and programme formulation, management and monitoring, as well as gender issues, particularly equality and the need to empower women to overcome challenges such as economic deprivation, violence, lack of access and control over productive resources, and others. Relevance therefore measures the extent to which development interventions (and in this context, the interventions of the 6th CP) meet the needs of the target beneficiaries. Based on this, we pose the following questions:

- Has the Country Programme addressed the needs and priorities of the people of Malawi in relation to access and utilisation of reproductive health services, HIV prevention, population and development, and gender equality?
- Did the programme focus on the most critical issues related to the promotion of ICDP agenda?
• Did the objectives and interventions of the programme address the highest priority needs of the target population?

• Did those needs evolve over the course of the programme? If new needs emerged, was the programme responsive to those needs?

• Were the programme’s targeted beneficiaries appropriate, given the context?

• Are there gaps in service, in terms of availability and/or quality that still need to be filled?

• Which activities being implemented in the 6th Country Programme could be replicated and/or scaled for use in other areas?

• Are the issues that the CP was designed to address still relevant?

**Sustainability**

Sustainability refers to the continuation of benefits from a development intervention after major development assistance has ended, including long-term benefits. It is also the resilience of net benefit flows to risk over time. Sustainability is a measure of whether the benefits of a development intervention are likely to continue after external support ends. Our questions therefore are:

• How is the CP promoting the sustainability of activities that are being supported in the community?

• What evidence is available for the sustainability of such programmes?

• How effective are the sustainability measures?

• Are there any sustainable and replicable practices that should be documented under the 6th CP?

**Impact**

The term ‘impact’ is used in different ways. In other contexts, it is seen as the broad, longer-term effects of specific work, or the institutional changes that result from interventions. In this evaluation, we consider impact to be the outcomes achieved in the 6th CP as measured by data from beneficiaries as well as implementation partners. Therefore, we ask the following questions:

• What impact has the 6th CP had on the lives of the people of Malawi in terms of reproductive health, HIV prevention and AIDS, gender equality, and population and development issues?

• According to the beneficiaries, what were the main impacts, both positive and negative, of the three main programmes?

• How have the CP interventions impacted the lives of vulnerable groups?
2 METHODOLOGICAL APPROACH

This evaluation employed both qualitative and quantitative methods. The evaluation was designed to involve the participation of UNFPA staff, their implementation partners and various beneficiaries at hospitals and clinics, as well as those in communities and villages.

In conducting this evaluation, we generated data by conducting focus group (FGDs) and key informant interviews (KIIs) with beneficiaries from target populations and partner institutions, making first-hand observations, and reviewing documents and literature, among others.

2.1 Literature Review

We conducted a comprehensive desk review of various related policy and planning instruments at both the international and national levels. The details of the documents reviewed during the evaluation are provided in the reference section. Presented in Table 1 below is a sample of some of the documents that were reviewed as a part of the evaluation:

Table 1: Initial List of Reviewed Documents

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<tr>
<th>International-Level Documents</th>
<th>National-Level Documents</th>
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<tbody>
<tr>
<td>• Millennium Development Goals progress review report</td>
<td>• The Malawi Growth and Development Strategy</td>
</tr>
<tr>
<td>• United Nations Development Assistance Framework</td>
<td>• Country Programme Action Plan</td>
</tr>
<tr>
<td>• International Conference on Population Development reports</td>
<td>• National HIV and AIDS Action Framework</td>
</tr>
<tr>
<td>• African Charter on Human Rights and People’s Rights on the Rights of Women in Africa</td>
<td>• National Response to Combat Gender-Based Violence</td>
</tr>
<tr>
<td>• SADC Gender Protocol</td>
<td>• Midterm evaluation report</td>
</tr>
<tr>
<td>• HIV and AIDS-related documents</td>
<td>• Partners’ annual progress and financial reports</td>
</tr>
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<td>• Programme evaluation reports</td>
</tr>
<tr>
<td></td>
<td>• SWAp/Health Sector review reports</td>
</tr>
<tr>
<td></td>
<td>• Reports of the SRH-TWG</td>
</tr>
</tbody>
</table>

These documents were reviewed to enable the evaluation team to achieve the following evaluation objectives:

- Establish the statuses of the major outcome areas for the 6th Country Programme. (The midterm evaluation was very useful in establishing some basis for measuring progress at the time of this final evaluation so as to determine the contribution of the program.)
- Determine the achievement of the programme against its goals, purposes and objectives, examining gaps (if any) in the design of the 6th CP.
- Determine the adequacy of objectives and monitoring indicators, particularly in relation to recommendations for future programme design.
- Establish the relevance and appropriateness of the programme.
• Determine the conformity of the programme to international and national development goals.

• Determine the overall impact of the 6th CP on the target population in Malawi.

2.2 Data Collection Instrument Development

In conducting the evaluation, data collection instruments were developed consistent with various research methods. We developed customised guidelines/checklists which were utilised during either FGDs or KIs that were conducted with relevant target community members and key persons from the sampled partners in outcome areas. These guides/checklists were essential for ensuring consistency amongst trained interviewers for data collection.

2.3 Briefing Meetings

At the beginning of the evaluation process, briefing meetings were held with relevant UNFPA staff and leaders to agree on the timeframe for data collection. Briefing meetings were continuously held to give progress updates, to seek clarification on issues, and to develop consensus positions on certain aspects of the evaluation as they emerged. For instance, after the inception report, the evaluation team embarked on a comprehensive desk review and developed data collection instruments. Once the tools were developed, they were submitted to the UNFPA for review, feedback, and validation. Further meetings were held to discuss the tools and obtain comments from UNFPA, at which point the team embarked on national, district and community-level consultations and interviews. At the end of data collection, a draft report was prepared and submitted to UNFPA for feedback. At a subsequent workshop, a presentation of the results was made, followed by discussion and feedback before the report was finalised.

2.4 Consultation and In-depth Interviews

The evaluation team conducted a wide range of consultations at the national, district and community levels. The consultations were conducted in four phases, as outlined below:

Stage 1 involved consulting with the client and government ministries working in partnership with UNFPA, as well as those providing services in the areas of reproductive health, HIV prevention, gender, and population and development.

Stage 2 focused on the head offices of the sampled implementing partners, where more information was obtained.

In Stage 3, interviews were conducted with implementing partners to elicit information on their progress, and to review annual and financial reports. Qualitative information on activities in the four main evaluation areas was collected during these interviews.

During the last phase, Stage 4, interviews were conducted at the district and community levels with the District Councils and beneficiaries or service recipients of the 6th CP. To examine efficiency and effectiveness specifically related to the decentralisation of decision making, we sought to discover the interactions and synergies created by District Councils, which have authority over development planning and implementation for districts in the country. In this
regard, the evaluation team examined the extent to which implementing partners collaborated with District Councils, the extent to which District Councils participated in the implementation of 6th CP interventions, as well as the extent to which the capacities of District Council skills and structures were built and strengthened to contribute to the sustainability of the interventions and benefits of the program.

We anticipated that at this point, important aspects of the evaluation would be established, as the resulting data would enable the team to establish the effectiveness, efficiency, relevance, sustainability and impact of the 6th CP.

2.5 Sampling

A multistage sampling technique was adopted to establish the sample of partners and communities involved in the evaluation. Multistage sampling involved a combination of simple, stratified and purposeful sampling. The multistage sampling strategy was considered to be appropriate, as it helped to save mileage and maximised the administration efficiency for this evaluation. Furthermore, by combining different techniques, the evaluation was able to achieve a rich variety of probabilistic sampling methods.

Our first approach in multistage sampling was purposeful in the sense that all national-level public ministries were consulted, as they are involved in different outcomes (reproductive health, HIV and AIDS, gender, and population services) related to the 6th CP. Purposeful methodology also helped to determine the sample of Civil Society Organisations (FBOs and secular) involved in the evaluation. Again, organisations were selected to participate in the evaluation based on the four outcome areas, since we anticipated a lot of intervention similarities among organisations working toward the same goals.

Random and purposeful sampling techniques were applied at the lowest sample level to determine the actual communities that would be interviewed in the evaluation.

In order to achieve a representative sample from all outcome areas of the 6th CP, we selected sufficient samples of various community groups and wider communities involved in different interventions supported by the 6th CP to be interviewed. The on-site interviews and consultations were reinforced by first-hand observations and changes that have taken place in the communities to determine the impact of the program.

2.5.1 Summary of Sampled Institutions

A total of 15 partner organisations were included in the interview sample. In each district, we conducted interviews in three district hospitals and one health centre under each of the sampled district hospitals. We interviewed medical assistants and community members at community health centres. We conducted FGDs and KIIs in villages in several groups. In what follows, we present the findings according to the three priority areas of UNFPA: reproductive health and HIV prevention, gender, and population and development.

A list of UNFPA implementing partners was presented to the evaluation team. We selected our sample to ensure adequate representation of the three outcome areas. Given the short time frame for conducting the evaluation, we selected 15 of the 29 UNFPA institutional partners to
interview. In our selection, we ensured the there was adequate representation of the three regions in the country.

The table below provides a summary of institutions that were selected. The final list of sampled partners was based on the outcome areas with which they were involved and their geographical locations. UNFPA provided information regarding geographical locations of interventions being carried out by the partners in order to ensure adequate representation in the sampling process. We made efforts to ensure that there was a generally acceptable distribution of the sampled partners and districts included in data collection.

**Table 2: List of Partners Interviewed**

<table>
<thead>
<tr>
<th>Implementing Partner</th>
<th>Outcome Area</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoDPC</td>
<td>Population and Development</td>
<td>Lilongwe</td>
</tr>
<tr>
<td>Chancellor College</td>
<td>Population and Development</td>
<td>Zomba</td>
</tr>
<tr>
<td>Family Planning Association of Malawi</td>
<td>Reproductive Health and HIV Prevention</td>
<td>Lilongwe</td>
</tr>
<tr>
<td>NGOGCN</td>
<td>Gender</td>
<td>Lilongwe</td>
</tr>
<tr>
<td>MoGCCD</td>
<td>Gender</td>
<td>Lilongwe and Rumphi</td>
</tr>
<tr>
<td>NSO</td>
<td>Population and Development</td>
<td>Zomba</td>
</tr>
<tr>
<td>MAGGA</td>
<td>Reproductive Health and HIV Prevention</td>
<td>Karonga and Lilongwe</td>
</tr>
<tr>
<td>NYCOM</td>
<td>Reproductive Health and HIV Prevention</td>
<td>Karonga and Lilongwe</td>
</tr>
<tr>
<td>MoH</td>
<td>Reproductive Health and HIV Prevention</td>
<td>Nkhata Bay, Mchinji</td>
</tr>
<tr>
<td>Pakachere</td>
<td>Reproductive Health and HIV Prevention</td>
<td>Blantyre</td>
</tr>
<tr>
<td>Malawi Law Commission</td>
<td>Gender</td>
<td>Lilongwe</td>
</tr>
<tr>
<td>YONECO</td>
<td>Reproductive Health and HIV Prevention; Gender</td>
<td>Zomba</td>
</tr>
<tr>
<td>Ecumenical Counselling Centre</td>
<td>Reproductive Health and HIV Prevention</td>
<td>Lilongwe</td>
</tr>
<tr>
<td>Mangochi District Hospital</td>
<td>Reproductive Health and HIV Prevention</td>
<td>Mangochi</td>
</tr>
</tbody>
</table>

### 2.6 Data Analysis, Interpretation and Reporting

All of the quantitative data collected from reports and documents from the IPs was analysed for patterns and trends to provide information for the production of the comprehensive evaluation report.
The qualitative data was subjected to content analysis, where key themes and concepts were generated within the major themes that emerged. This process was then followed by a systematic comparison of statements/findings from the FGDs and KII. The evaluation team performed a detailed thematic analysis to produce a draft report.

The draft report was presented to the UNFPA staff and key stakeholders at a workshop at the UNFPA office in Lilongwe on December 9, 2010 for discussion and feedback. Following the workshop, the team incorporated all agreed upon feedback into the report and the final evaluation report was produced.
3 PROGRAMME RELEVANCE, APPROPRIATENESS AND EFFICIENCY

3.1 Programme Relevance and Appropriateness

The GoM/UNFPA 6th CP is based on a relationship that exists with the United Nations Development Programme (UNDP) which came into being in 1997 and provides the legal basis for the partnership between the GoM and UNFPA. The 6th CP is a programme implemented by UNFPA as a way of operationalising the United Nations Development Assistance Framework (UNDAF) for the period between 2008 and 2011. The UNDAF is the programmatic response of the UN system to the development requirements and priorities of Malawi with a central purpose of assisting Malawi to achieve the Millennium Development Goals (MDGs). In the context of Malawi as a country, the MDGs are articulated and contextualized in the Malawi Growth and Development Strategy (MGDS). The MGDS is the overall five-year strategy for the country (2006-2011). As indicated earlier, the MGDS provide the socio-economic policy framework for attaining the medium-term objectives of the country.

The overall goal of the 6th CP, which aims at improving the quality of life of the people of Malawi through improvement in reproductive health status, prevention of HIV, increased gender equality and the empowerment of women, and favourable interactions between population dynamics and development, is not only in alignment with the outcomes of the UNDAF, but also with the MGDS, rendering it relevant to the needs and development priorities of the country. Through the CPAP, the 6th CP addresses important population and development issues for Malawi. Focussing on sexual and reproductive health, HIV/AIDS, gender equality, and the integration of population variables into development makes the programme an appropriate and important tool for the GoM as it aims to improve the social development of its citizens.

3.2 Programme Efficiency

Overall, the programme has been efficient, as evidenced by achievements in each of the components. The current evaluation is, however, in agreement with the midterm evaluation, which noted some late fund disbursements. The view of the evaluation team is that the delays in disbursement are a result of both normal system functions and IP behaviors. The UN system requires that all funds for various agencies be kept at the UNDP, which facilitates all payment. In some cases, due to unforeseen circumstances, even when UNFPA authorises the disbursement of funds, the UNDP delays their release. Similarly, partners sometimes neglect to reconcile and account for initial instalments received, which delays access to subsequent instalments and affects the implementation of activities. As indicated, the evaluation did not find any serious delays in fund disbursement that significantly affected the implementation of activities and their impacts on target communities.

3.3 Institutional Arrangements

3.3.1 UNFPA Country Office

There are about 25 full-time staff members, including specialist consultants employed in the UNFPA Country Office (CO). There are three programmatic divisions and other cross-functional sections, such as Operations, and Monitoring and Evaluation that employ approximately 13 local professionals under the leadership of the Country Representative and
the Deputy Country Representative. The distribution of the main staff in the programmatic divisions and the cross-functional sections is as follows:

### Table 3: Distribution of CO Staff

<table>
<thead>
<tr>
<th>Division/Section</th>
<th>Number of Staff Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Leadership (CO Rep. &amp; Deputy Rep)</td>
<td>2</td>
</tr>
<tr>
<td>Operations/Finance</td>
<td>3</td>
</tr>
<tr>
<td>Monitoring &amp; Evaluation</td>
<td>1</td>
</tr>
<tr>
<td>Reproductive Health &amp; HIV Prevention</td>
<td>6</td>
</tr>
<tr>
<td>Population and Development</td>
<td>2</td>
</tr>
<tr>
<td>Gender</td>
<td>1</td>
</tr>
</tbody>
</table>

Accounting for overlaps in the work related to each of the sub-programmes, the staff allocation to each area of work corresponds reasonably well with the programme budget. The majority of the staff, as indicated above, are Malawians and they have suitable qualifications (Ph.D./M.Sc. for programme officers, and B.S. for assistants and coordinators) and experience to implement impactful country programs. Most of these staff members have immense experience in their areas of specialisation, having had practical work experience with international NGOs or the GoM before joining UNFPA. The CO is further supporting the recruitment of other international and local experts to strengthen programme management and increase effectiveness at the partner level. This will include recruiting an international RH expert who will be based in the Reproductive Health Unit (RHU) of the Ministry of Health (MoH) and two other staff members, who will be based in the Ministry of Gender, Children, and Community Development (MoGCCD).

The rest of the institutional arrangement for the implementation of the 6th CP (with a few exceptions that might have not been considered) was observed as follows:

- The UNFPA Country Office (CO) leads activities related to the 6th CP implementation, including coordinating and mobilising resources and providing technical expertise. The capacity of the UNFPA CO to manage the implementation of the CP is very strong and has constantly been strengthened with the presence of a Resident Representative and his/her deputy

- The availability of professional and expert staff has been significant for the effectiveness of the UNFPA as an organisation. Staffing has been steady, and the staff composition has been strengthened when necessary.

### 3.3.2 GoM Coordination Mechanism

- The MoDPC has been playing its role as the coordinating agency for the implementation of the 6th CP on behalf of the GoM with support from the CO. However, its effectiveness to
coordinate has been undermined by inadequate capacity. The MoDPC’s relevant division is somewhat understaffed, yet it is anticipated to have the added responsibility of having to administer the National Population Policy implementation process once it is approved by the Cabinet. It was pleasing to note, however, that there are plans to strengthen the unit so as to increase its effectiveness in terms of programme coordination and implementation monitoring with support from the CO.

- Arrangements for monitoring the implementation of the CP have been put in place, with the MoDPC population department being the responsible agency. Progress reports have been prepared periodically through a monitoring system; however, the system is limited in terms of its correspondence with indicators outlined in the CPAP tracking tool. There was evidence of regular annual progress review meetings involving all partners. There was also evidence of partners working together within the same outcome area, although these meetings were not institutionalised and intermittent. Considering the dynamic nature of development issues, which are influenced by a wide range of factors, it may be worth considering a semi-annual performance review process so as to provide the opportunity for feedback and accountability every six months. This would bolster experience-sharing among all parties involved in implementing the CP. These performance reviews should be held at times outside of the regularly scheduled quarterly visits by programme officers, which occasionally do not happen due to other engagements often related to capacity-building for the UNFPA.

3.3.3 Implementing Partners and Partnerships

- The implementation of the CP is done through a wide range of partners who are organised according to outcome areas. As indicated earlier, these include government ministries and departments, district hospitals, NGOs and faith-based organisations/institutions. The number of implementing partners has remained constant throughout the 6th CP, and there are plans to expand the partner base. The addition of new partners should be commensurate with achieving outcomes and/or securing additional funding. Otherwise, the impact of the programme could be undermined, since resources would be overstretched. The evaluation noted that the annual budgets that were made available to partners were somewhat meagre (some as low as 100,000 USD per annum) against a mountain of activities requiring attention.

- Partnerships have been forged with other UN agencies within the context of delivering as one approach, which is aimed at avoiding duplication of efforts. UNFPA actively participates in cluster three with UNICEF and WHO. UNFPA has demonstrated leadership as an institution, providing leadership for the UN subgroup on HIV and AIDS, and chairing the Gender group for UN agencies. UNFPA has also taken leadership on a wide range of issues, and has been exemplary in working with other development partners, as well as mobilising resources for national level events. The case of the 2008 PHC is one case in which UNFPA coordinated and mobilised resources, thereby facilitating successful completion of the activity.
3.3.4 Issues in Programme Design and Implementation Strategy

As observed earlier, programme design for the 6th CP was informed and guided by several instruments. The evaluation established that on one hand, the findings and lessons from previous Country Programmes (CPs) were taken into consideration. This enhanced the responsiveness of the 6th CP, and learning became a true aspect of the design process. On the other hand, international and national development frameworks coupled with the development agenda of the UN (in the form of the UNDAF) informed and guided the design of the program. Thus, the programme design was not only based on the UN Development Framework for assistance in Malawi, but was also responsive and sensitive to the emerging social development needs of the country.

In addition, the design of programmatic strategies and activities was based on situation analysis of the outcome areas. Specific strategic activities for each of the outputs were adequately linked to the outcome areas, which in turn made them relevant to achieving the overall programme goal. In a nutshell, strong links existed between the situations, outcome areas, strategies and programmatic activities. This was a key measure of the progress the programme has made and its strong contribution to improving quality of life, as desired by the country and expressed in the MGDS.

The delivery and implementation of the programme was based on the participation of local institutions, capacity building in its entirety, and learning enhancement through shared experiences. As indicated earlier, the programme was implemented through strategically-identified partners based on areas of competitive advantage, expertise and capacity to deliver.

UNFPA uses a results-based approach, which also guides it in the identification of partners. The partners have been critical to the progress 6th CP has made. However, the number of current partners is adequate relative to the resources available. Therefore, it is our recommendation that no new partners be added at this time. In our evaluation, we found that planned activities are sometimes scaled down in response to funding limitations and to high expectations imposed by UNFPA headquarters. Therefore, adding new partners would only overstretch already limited resources, likely undermining the reasonable impact of programs.
4 FINDINGS, DISCUSSIONS AND INTERPRETATIONS

4.1 Sexual Reproductive Health and HIV Prevention

The goal of the UNFPA Country Programme is to contribute to improving quality of life for the people of Malawi by providing quality reproductive health services and preventing HIV and AIDS, in line with the United Nations Development Assistance Framework (UNDAF), the Malawi Growth and Development Strategy (MGDS) and the Millennium Development Goals (MDGs). In Malawi, reproductive health and HIV prevention activities are based on the SRHR policy and strategic plan, the Road Map for Reduction of Maternal and Neonatal Morbidity and Mortality, the HIV/AIDS Policy and the NAF which were developed in line with the Maputo Plan of Action. In order to increase access to integrated reproductive health services, UNFPA focused on supporting high-quality, gender-sensitive and integrated reproductive health services, including adolescent sexual reproductive health services, emergency obstetric care and HIV prevention services. The Country Programme achieved these goals based on the two outputs of: Increased availability of quality, integrated gender health and HIV/AIDS information and services for women, men and young people and increasing the availability of life skills education for young people.

In order to achieve these outputs, needs assessment exercises were conducted by implementing partners to determine the magnitude of the Sexual reproductive health problems which informed the designing and planning of interventions. Following the assessment, traditional and community leaders and village health committees were sensitized on the findings by the implementing partners that revealed issues related with environment, hygiene and nutrition; they were also educated about of the importance of antenatal care. Likewise, all relevant calibres of health workers such as HSA, nurses and others as well as safe motherhood committees were informed of the benefits associated with hospital deliveries.

Capacity building activities included training CBDAs to provide family planning services at the community level and reorienting TBAs to their new roles of encouraging and educating pregnant mothers on the importance of health facility delivery. Other activities included community awareness through open days and health talks. Other strategies were also used to realise this output, including: strengthening quality assurance in the delivery of integrated SRH services, including emergency obstetric care; incorporating family life education into basic education; and establishing youth-friendly services. Major activities included: establishing quality assurance teams at all levels of the health care system; developing and implementing a quality assurance monitoring tool at district level, conducting EMOC training and reviewing existing SRH protocols/manuals; training service providers to provide high-quality, youth-friendly services using revised manuals; and establishing and equipping youth-friendly service providers. Furthermore, the programme assisted in the development of IEC materials on SRH.

4.1.1 Increased Availability of Quality, Integrated, Gender-Sensitive Sexual and Reproductive Health and HIV and AIDS Services

Policy and advocacy
UNFPA in collaboration with other development partners and UN agencies, under the leadership of the MoH RHU, launched a campaign on the acceleration of reduction of MMR in Malawi. Furthermore UNFPA assisted the Ministry of Health-RHU in hiring a consultant to review the National Sexual and Reproductive Health and Rights Policy. The policy was approved and is in use to guide the implementation of SRH initiatives in the country.

UNFPA also made a significant investment in building national capacity by strengthening several NGOs and improving knowledge and awareness about reproductive health programme management, monitoring and evaluation.

The revision of Sexual and Reproductive Health Policy took cognizant of the elements as outlined within the Maputo Plan of Action. Emerging issues which were missing in the previous SRHR policy included: revised roles of Enrolled/ Nurses and midwives/Nurse Midwives Technicians to provide other signal functions like (Vacuum extraction, MVA, Removal of retained placenta) to enable them to provide Basic Emergency Obstetric Care; - New services such as cancer screening; - Prevention and management of obstetric fistula; male involvement and - Promotion and dispensing of the female condom. The policy was also reviewed to take into consideration the following documents which were developed after the development of the 2002 RH Policy: - The Africa Union SRH Policy Guidelines, - The Africa Union Health Strategy, - The Southern Africa Development Community Health strategy, - The Malawi Reproductive Health strategy 2006-2010, - The Road Map for the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi, and – The Malawi Accelerated Child Survival and Development Strategy.

Provision of Technical Assistants within the Ministry of Health. RHCS was also strengthened through the inclusion of the female condom in the LMIS. This has allowed for the integration of female condoms in the national monitoring frameworks of all RH commodities.

Increased access to high quality reproductive health services

The UNFPA CP plan facilitated high quality reproductive health services by mobilising communities, involving males, improving access and availability of quality maternal and child health services, STI and PMTCT, strengthening health services for young people, and providing HIV prevention services.

Increased community mobilisation and awareness at the community level

In order to increase community mobilisation and advocacy, safe motherhood committees were established to promote awareness of the importance of healthcare at all stages of reproduction: pre-conception, pregnancy, delivery, and post-delivery. At the pre-conception stage, family planning counselling and fertility counselling services are offered. In addition to promoting healthcare during pregnancy, these committees help women prepare for birth and encourage women to deliver at health facilities where they can be attended to by skilled health personnel. They also reinforce the importance of antenatal care; under five care and referring women with Obstetric Fistula (OF) to medical practitioners. The committee also provides services to young people, such as IEC on various health issues, recreation activities and family planning services.
Services such as family planning and BEmONC have improved lives of people in the area because they are available and accessible. For example, one woman who had obstetric fistula before the Programme started was referred to the central hospital and her condition was treated successfully. All the communities have access to the information on the services offered by these committees.

**Improved access and availability of maternal and child health services**

**Increased community referral to health services.**

Due to increased interventions by committees at the community level, there is now close monitoring of pregnant women. Once women are pregnant, they are identified by the safe motherhood committee members. The safe motherhood committee encourages couples to attend ANC so as to access related services including PMTCT and provides nutrition education. Couples' counselling is offered on pregnancy, childbirth preparation and the importance of hospital delivery. Integrated SRH and HIV care is the desired strategy of increasing access to services. This approach ensures that women seeking MNH and FP services also obtain HTC services and that clients seeking HTC services also obtain FP services. Outreach services developed with UNFPA support provide integrated services. The Nkhatabay outreach programme for hard-to-reach areas provides integrated services. However, support systems for the implementation of integrated services remain a challenge due to transportation problems.

Villages have developed initiatives to prevent maternal deaths. They have formulated By-laws to penalise those who deliver at TBAs. In the village of Pitala in Mchinji District, for example, if a pregnant woman delivers a baby at a TBA, the woman, her husband, the TBA, and the village headman are each fined a goat. Based on a report by a Nkhabay village head man, all pregnant women are strongly motivated to deliver at the hospital as a result. For failure to deliver at a health centre, in Nkhabay in Mzenga a penalty of two chickens is imposed to the couple who delivers at a TBA/home. This is a strong indication of how the village in Mzenga in Nkhabay has embraced the importance of delivering at a health centre with trained health personnel. Such progress is a direct result of the facilitation and education processes that have been implemented in various communities across the country through the 6th CP.

Due to increased successful efforts at discouraging home deliveries with the support of TBAs, there are now more women delivering at health centres than before. (see figure 1).

**Table 4: Number of Maternal Deaths in Nkhabay**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MD death</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>19</td>
</tr>
<tr>
<td>2001</td>
<td>18</td>
</tr>
<tr>
<td>2002</td>
<td>14</td>
</tr>
<tr>
<td>2003</td>
<td>13</td>
</tr>
<tr>
<td>2004</td>
<td>11</td>
</tr>
<tr>
<td>2005</td>
<td>9</td>
</tr>
<tr>
<td>2006</td>
<td>7</td>
</tr>
<tr>
<td>2007</td>
<td>7</td>
</tr>
</tbody>
</table>
Table 4 shows the number of maternal deaths from 2000 to 2010. The numbers have increased in 2010 due to a number of factors. Even though personnel are trained in obstetric life saving skills and are able to identify complications in the hospitals, bad road conditions present challenges in transporting expectant mothers to the hospital. It is reported that TBAs continue to deliver babies in some villages while other villages have reoriented TBAs into other non-delivery roles in supporting pregnant women. Despite the reorientation of TBAs to the new roles, some TBAs are still conducting deliveries, with complications resulting in maternal deaths at the district hospital. Another reason why there are more maternal deaths at the district hospital is due to sepsis and a shortage of screened blood from MBTS, as districts are no longer allowed to screen blood.

**Increased community MNH initiatives.**

Increased referrals have resulted in behaviour and attitude changes toward pregnancy and delivery. Due to efforts in Pilatas village, in TA Mkanda in Mchinji, there have been no maternal deaths since 2005 (see Table 5 below). Through a safe help project, the community moulded bricks and built a waiting shelter attached to the health centre to ensure that pregnant mothers are close to the hospital to avoid delays due to long distances and bad roads to the health centre. At Mzenga health center, in Nkhatabay the community moulded bricks in 2003 for female and male wards to ease congestion at the health centre, which had only two beds. Mzenga health centre is 85 km away from Nkhatabay district hospital, and there is no ambulance.

**Table 5: Maternal Deaths in Selected Health Centres**

<table>
<thead>
<tr>
<th>Year</th>
<th>Mkanda (Mchinji)</th>
<th>Nkhwazi (Mchinji)</th>
<th>Mzenga (Nkhatabay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>11</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>2001</td>
<td>9</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>2002</td>
<td>5</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>2003</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2004</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2005</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2007</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2008</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2009</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2010</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Evaluation Data from Health Centres
**Increased use of ANC services.**

Due to increased initiatives by community committees, there is increased male participation in ANC and more women are attending ANC in the first trimester. Even more encouraging is the fact that the village committees are recommending couples' counselling for PMTCT to all pregnant women and their spouses.

**Increased health facility deliveries by skilled workers.**

The impact of community MNH initiatives has resulted in an increase in health facility deliveries by skilled attendants. For instance, in Nkhatabay, skilled delivery was at 35% in 2000 but has now increased to 48% (HIM Nkhatabay). At Mkanda health Centre the number of deliveries has increased from 14 per month in 2006 to 140 per month in 2010 (see figure 1 below). During the evaluation, it was reported that Mkanda health centre has had more deliveries than before, with no home deliveries and no babies being delivered on the way to the hospital (see Figure 1 below).
The figure above shows record keeping at Mkanda health centre. The record clearly demonstrates that delivery at this centre has tripled in the past few years. Between 2008 and 2009 alone, the rate went from 1039 to 1774 with the level of trained personnel remaining unchanged during the same period.

**Increased access to family planning services.**

There has been a noticeable increase in the use of family planning commodities at both the community and facility levels. More women are aware of FP services and are able to obtain contraception locally, since CBDAs are providing the services right in the communities. In addition to contraceptive pills, CBDAs also provide condoms (both male and female). Safe
motherhood committees have educated males on the importance of family planning. The services have enabled people to increase child spacing periods, hence allowing their children to grow in good health. The services have further enhanced maternal health, thereby reducing maternal deaths and morbidity. The increased access to family planning services has also led to manageable family sizes, improving household economic statuses.

**Strengthening services that promote HIV prevention among young people**

**Increased investment in government initiatives.**

The youth profile in Malawi indicates that out of the estimated population of 13.1 million (2008 Population and Housing Census), 19% are between 15 and 24 years old. Because of poverty and minimal investments in education and health, the majority of young people lack basic opportunities that would enable them to develop their full potential. Unequal access to already limited opportunities has further increased vulnerability among adolescent girls and young women, and put them at greater risk of HIV and STI infections and other sexual and reproductive health risks, including physical, psychological, and/or those associated with sexual violence. Adolescent pregnancies comprise 25% of all births and 20% of maternal deaths. HIV prevalence among young people aged 15-24 is estimated at 6 percent and is higher among females (9.1 percent) than males (0.4 percent).

Yet, the majority of young people have limited access to sexual and reproductive health services and their knowledge and practices related to sexual and reproductive health must be improved. Less than half of the population has correct knowledge about HIV/AIDS (42.1% for both male and female) and less than half of them use condoms during sex with non-regular or casual partners (47% for male and 30% for female).

The government of Malawi and other development partners have increased their support for the SRH section to invest more resources in the development of adolescents and young people. A youth-friendly strategy and implementation framework was developed, and progress has been made toward building capacity of youth-friendly service providers at both the national and district levels, including pre-service training. To facilitate the implementation and coordination of the youth program, youth-friendly district health sub-committees and youth action committees at TA levels were formed. Operational standards and tools for the implementation, monitoring and supervision of youth-friendly health services were developed and in use for quality assurance purposes.

However, the proportion of health facilities currently providing YFHS is still low according to national standards. Inadequate coordination at the district level, low sensitisation at the community level, and insufficient coordination between the Ministry of Health and Ministry of Youth still must be addressed in order to increase the quality YFHS at all levels.

FPAM has been receiving technical and financial support from UNFPA and other funding sources to address issues of access to SRH information and services for young people. Through this support, young people have accessed sexual and reproductive health information on the dangers of unwanted pregnancies, the prevention and treatment of HIV and AIDS, voluntary counselling and testing, family planning, safer sexual practices, the prevention and treatment of sexually transmitted infections, the dangers of sex work and other livelihood options for young
women and girls engaged in it, gender, and other aspects related to sexual and reproductive health. In addition, FPAM has been providing sexual and reproductive health services through its uniquely branded “Youth Life Centres”, where young people and other clients are treated with dignity, respect and observance of standards of youth care where rights of a client are practised.

Over the years, FPAM has expanded its delivery points and coverage range to broaden service choices for clients. FPAM now boasts three fully operational Youth Life Centres, complete with clinics offering family planning, including long-term contraception methods, treatment of sexually transmitted infections, voluntary counselling and testing, management of opportunistic infections, referral services for ART, post-abortion care, screening for cervical cancer using visual inspection, emergency contraception and treatment of general ailments. These services are provided in an integrated manner, allowing clients to obtain more than one service in a visit. Furthermore, FPAM has established strategic points in the community where services are provided on a mobile/outreach basis including markets and hot spots for sex workers.

During the evaluation, FPAM highlighted some interim results of the service provision component, which has been supported by UNFPA and other donors to improve access to services, particularly for young people during 2009. FPAM is contributing to UNDAF outcomes by increasing equitable access to and use of basic social services. Likewise, they have developed a national response to HIV/AIDS which will be scaled up by 2011 to achieve universal access to prevention, treatment, care and support. FPAM is also contributing to equitable access to reproductive health and HIV prevention services by increasing the availability of quality, integrated, gender-sensitive sexual and reproductive health information and services as well as increasing the availability of life skills education for young people both in and out of school.

The total number of clients seen by FPAM for various services in 2009 was 22,088. Out of these, 13,888 used SRH services and 8,200 were attended for general ailments. In summary, Table 6 presents services provided by FPAM in 2009 by age, sex and socio-economic background.
Table 6: Distribution of Clients for Family Planning Services

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Male</th>
<th>10-24</th>
<th>25 plus</th>
<th>Female</th>
<th>&lt;10</th>
<th>10-24</th>
<th>25 plus</th>
<th>Total per service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>188</td>
<td>86</td>
<td>0 1867 3381 5522</td>
</tr>
<tr>
<td>Emergency Contraception</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 118 98 216</td>
</tr>
<tr>
<td>Sexually Transmitted Infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>128</td>
<td>259</td>
<td>0 229 420 1036</td>
</tr>
<tr>
<td>Pregnancy Tests</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 387 332 719</td>
</tr>
<tr>
<td>VCT</td>
<td>9</td>
<td>1133</td>
<td>1354</td>
<td>15</td>
<td>2206</td>
<td>1409</td>
<td></td>
<td>6126</td>
</tr>
<tr>
<td>Opportunistic Infections</td>
<td>2</td>
<td>15</td>
<td>37</td>
<td>14</td>
<td>38</td>
<td>59</td>
<td></td>
<td>165</td>
</tr>
<tr>
<td>Cervical Cancer Screening (VIIA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>85</td>
<td></td>
<td>101</td>
</tr>
<tr>
<td>Post Abortion Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>General Medical cases</td>
<td>1120</td>
<td>898</td>
<td>1445</td>
<td>1079</td>
<td>1489</td>
<td>2169</td>
<td></td>
<td>8200</td>
</tr>
<tr>
<td>Totals by age</td>
<td>1131</td>
<td>2362</td>
<td>3181</td>
<td>1108</td>
<td>6352</td>
<td>7954</td>
<td></td>
<td>22088</td>
</tr>
</tbody>
</table>

| SRH Services                         | 11   | 1464  | 1736    | 29     | 4863| 5785  |          | 13888             |
| General cases                        | 1120 | 898   | 1445    | 1079   | 1489| 2169  |          | 8200              |
| Attendance % by age and sex          |      |       |         |        | 5   | 11    | 14      | 5 29 36 100     |
| %SRH Services attend -age & sex     | 0    | 11    | 13      | 0      | 35  | 42    |          | 100               |

**Increased training of peer educators.**

With funding from UNFPA, a number of organisations like NYCOM, MAGGA, FPAM and district hospitals have trained peer educators among youth both in and out of school. In addition, girl guides who are teachers have also been trained in life skills. These peer educators encourage girls to continue with their educations and convince girls who have dropped out (due to pregnancy) to return to school. Peer educators are also responsible for conducting HIV and AIDS prevention awareness campaigns in the communities, sensitising girls to dressing properly to discourage unwanted attention from the opposite sex, conducting behaviour change training aimed at harmful cultural practices such as kupimbira (a practice in which a female child is offered in marriage to a wealthy man to pay debts or pre-arranged marriage). This is done through life skills education. Peer educators use role modelling to encourage girls to have aspirations, and inspire them to gain independence by engaging in small businesses such as selling fritters and usipa. In Karonga, through MAGGA 7 out of 11 were trained as peer educators to target groups like Rainbows (3-5 years), Brownies (6-10 years), Girl Guides (11-14 years), Rangers (15-19 years) and Cadets (20-25 years).

In Mzenga, Nkhabatay, several youth training initiatives exist to reduce alcohol consumption, unsafe sexual behaviours, and drug and substance abuse. Additionally, gender equity and human rights awareness are promoted along with female school attendance.

The evaluation established, however, that UNFPA support was phased out for facilities hosting youth recreational activities such as chess and bawo in 2005. Currently, only the District
hospital provides assistance through the support that it gets from MANASO for SRH initiatives and the distribution of IEC materials such as posters.

In terms of reproductive health, FPAM trains youths to prevent teenage pregnancies. They encourage young people to wait until they are mature enough before they have children or get married. They also sensitisise and educate the youth on the importance of education.

Further, access to family planning resources and contraceptives had improved when UNFPA was supporting the initiatives. At the time of the evaluation, the services were reported to have dramatically declined and the only available contraceptive at the health centre was Jadelle. Likewise, it was noted that both male and female condoms had not been available at the district and health centres as well as at community level (CBDAs) since September 2010. This means that at the time of this evaluation, condoms had not been distributed to youths for 3 months. Worse still, condoms had been provided preferentially to married couples over the youth; as such, the youth had almost no access to them, which increased their vulnerability to unwanted pregnancies, as well as STI and HIV infection. In addition, this situation is undermining the gains that had been made in reducing maternal, infant and neonatal mortality, and is negatively impacting the goal of increasing access and utilisation of contraceptives such as birth control pills, Depo and condoms.

**Increased youth access to HTC.**

Peer education has increased access to information and education on HTC services. More youth are able to access services through peers. In Karonga, they have opened AIDS Toto clubs in secondary school. The awareness campaigns have helped to reduce stigmatisation. More people are going for VCT in this area than before, and there is openness about sero status.

RH services have helped to modify some harmful cultural practices such as chokolo (wife inheritance) where the brother to the deceased inherits the responsibility of caring for the family without being expected to marry the brother’s wife. In addition, condom use has increased due to sensitisation campaigns. Chronic and AIDS-related illnesses have also been reduced. However, activities have been scaled down in community-based care due to reduced funding for other necessary activities. This notwithstanding, the evaluation has established that there is increased community participation in caring for OVCs and other vulnerable groups.

### 4.1.2 Increased Availability of Life Skills Education for Young People in and out of School

Capacity-building and training was conducted for out-of-school youth on HIV and AIDS prevention and family planning. Youth centres placed within communities have also provided out-of-school youth with recreational facilities and environments for interaction without necessarily engaging in sexual activities. In-school youth have been reached as well, with innovative approaches designed to motivate delayed onset of sexual activity and to help youths handle peer pressure. The approaches included the use of role models and mentors who were identified and trained to mobilise in-school youth on SRH and HIV prevention issues.

From 2002 to 2007, the Girl Guides of Malawi programme was implemented in 3 districts, Lilongwe, Blantyre and Mzuzu/Mzimba North. In 2008, it was scaled up to Mangochi, Mchinji and Karonga districts. The programme is currently being implemented in the following 6
districts: Lilongwe and Mchinji in the Central Region, Blantyre and Mangochi in the Southern Region and Mzuzu/Mzimba North and Karonga in the Northern Region.

Activities include:

- Peer education trainings
- Peer education sessions
- Zone-based life skills trainings
- Zone-based social mobilisation meetings with community leaders
- District-level advocacy meetings on SRH issues affecting girls and young women with traditional authorities, group village headmen, educational authorities and DEC members (two completed this year in Mangochi and Karonga districts)
- Zone-based life skills open days
- Regional girls congresses
- Regional camps
- Peer educator review meetings
- Monitoring and supervision visits
- Project evaluation (2008) and baseline survey (2002)
- Develop and print IEC materials
- Procure and distribute bicycles and recreation materials

The primary target population for life skills development activities is girls and young women aged 10-24 years. So far, MAGGA has managed to positively influence the lives of 27,787 girls and young women by providing them with adequate and accurate life skills-based information focusing on SRH, HIV and AIDS and other related issues. They participate in dung bells (a game), HIV and AIDS training, and community outreach programs. They go to the villages and help the elderly by fetching water for them. They also perform drama, traditional songs and poems on issues related to HIV and AIDS. In terms of life skills, they are taught about peer pressure and the importance of not dropping out of school; those who drop out of school often re-enroll. They also learn that males and females are equal, both in school and from other teachers and peer educators.

DEC members, SMCs, community leaders (chiefs, TAs), and the communities at large have been sensitised. They work with the schools to create programmes and involve school leaders who have been trained as peer educators. They also train primary school girls who inform their classmates about the activities. The community is very pleased with the programme, because most of the girls’ problems have been alleviated, especially in terms of RH and HIV prevention. The school dropout rate has been reduced. Girls have learned different skills such as making door mats and knitting school bags. There has been a significant reduction in gender-based
violence among girls, with increased reporting of GBV cases to the relevant authorities. PSI also facilitates VCT services at the school.

Life skills training are being implemented by IPs, especially amongst the youth. This is an important intervention that has the potential to empower youth to delay sexual activity, avoid teenage pregnancy and contribute towards reducing the incidence of HIV infection among this vulnerable population.

**Strengthening RH commodity security**

Reproductive health commodities and equipment are needed to support all programme interventions contained in the UNFPA plans for sexual and reproductive health. The current status according to the 2009 physical inventory is some reproductive health commodities ran out of stock at health facilities across the country. In addition, health providers do not always have the appropriate tools or knowledge required to manage health commodities.

The reproductive health commodity security strategy has been drafted and incorporated into the RH strategy, examining four areas of the commodity security framework to ensure that every Malawian is able to choose, obtain and use quality reproductive health products, including contraceptives, whenever she or he needs them.

Reproductive health commodity security depends on commitment by all stakeholders, evidenced in part by supportive policies, government leadership and focused advocacy. It is the basis for stakeholder investments of necessary capital (financing). The government, private sector and NGOs need to coordinate activities for commodity security (CS), and develop necessary capacities to ensure it. Capacities must exist for a range of supply chain functions, including policy creation, forecasting, procurement, and distribution, as well as supervision, monitoring and evaluation. During the evaluation, it was noted that most basic supplies were out of stock. These include contraceptives (DMPA, pills), reagents and blood for transfusions, condoms, and sterile gloves. Most of the contraceptives had been out of stock for two months in most of the facilities. It is clear: No product, no program. Only FPAM had all the necessary products because they buy their own commodities instead of using the ones that are channelled through central medical stores. Although UNFPA is involved in the procurement of commodities like condoms and contraceptives, its partners do not access the products because DHOs are required to order according to allocated budgets.

**Challenges**

The implementing partners face a number of challenges affecting programme implementations.

**Congestion in waiting shelters**

Most mothers-to-be live very far away from health centres, and they would prefer to move to waiting shelters at the health centres before the onset of labour. The waiting shelters, however, cannot accommodate pregnant women and their relatives. This resulting congestion can create unhealthy living environments for pregnant women.

**Transportation and Communication**
Difficult terrain and poor roads are major structural barriers to reducing maternal mortality. Nkhatabay motor bicycles cannot be used as a means of transportation on these bad roads. Moreover, maintaining these motor bicycles for road worthiness is major challenge. Some health centres like Mzenga have no permanent ambulances. Mzenga serves three health centres in the surrounding area, and is 85 kms away from Nkhatabay Boma. Radio communication systems are not working in most of the health facilities. Inadequate transport in UNFPA focus districts makes DHMT and programme coordination and supervision difficult.

**Funding delays**

Most of the implementing partners complained of delays in funding. Most of the time, they receive the first funding instalment in the second quarter. This negatively impacts the partners, making it difficult for them to implement activities as planned.

**Youth recreation facilities**

The program was pivotal in improving YFHS by increasing capacities of YFHS facilities and clubs. For instance in Karonga, the National Youth Council provided TV sets to enable the youth watch educative programs and have meaningful entertainment. The result has been that the youth productively spend time which is otherwise spent on life threatening issues. In spite of this, some facilities and clubs do not have adequate recreation facilities such as balls, and indoor games such as chess, pool and table tennis to ensure that that the facilities are comprehensively supplied with all required things that would make them complete facilities. For instance in Nkhatabay at the district hospital there is only bawo, because the balls were damaged and can no longer be used. Most of the youth have nothing to play with and are therefore discouraged from using the facilities. This has resulted in low patronage of youth services.

**Human resource crisis**

Most of the health centres have inadequate staff compared to the recommended staff levels; as such, one nurse works twenty-four hours a day. According to the establishment, there are two nurses and two medical assistants per health centre. Consequently staff workload is increased thereby affecting the quality of output.

**Chronic lack of commodities and supplies**

Almost all districts reported stock-outs of commodities and supplies for reproductive health, on everything from basic equipment to contraceptives, with contraceptive stock-outs being ranked number one. It was reported that contraceptives had been out of stock for two months.

**Inoperable wireless radio wireless communication**

During the evaluation, it was noted that in most of the health centres, radio communication systems were not working, making communication to referral hospitals impossible. This causes delays in referring clients.

**Lack of blood available for transfusion**
Some of the maternal deaths are due to post-partum haemorrhaging which can not be treated as an emergency because of lack of availability of the blood for transfusion. For instant in Nkhatabay the bank is always empty. All blood is screened at either the central blood bank in Lilongwe or its branch office in Mzuzu. The blood supply is not enough for the whole country. It is very difficult to get screened blood in time during emergencies. Couple this with the fact that Nkhatabay has no blood bank to store blood. Clearly, the blood bank situation must be fixed.

**Poor infrastructure at Mzenga Health Centre**

This health centre is 85 km away from Nkhatabay, and serves communities surrounding three other health centres but does not have ambulance services. Additionally, the health centre has no admission rooms; there is one tiny room with two beds, for both male and female clients. However in a bid to participate in the activities of the Health centre, the community has moulded bricks to build an admission room and it would be appropriate on the part of the program to consider supporting the community by supplying it with provisions that would facilitate the expansion and construction of the required additional admission rooms.

**Financial regulations not clear**

While a majority of the implementing partners expressed appreciation for the resources from UNFPA, they expressed a strong need for technical guidance on implementation of the planned activities and finances.

**High turnover rate of volunteers**

Most of the community work is done by volunteers like CBDAs and safe motherhood committees. Sustaining volunteers has been a challenge, and most of the time they leave for salaried jobs.

### 4.2 Population and Development

The population and development component focused its activities around outcomes to ensure improved national capacity to use population data for policy formulation, management and monitoring. To achieve this outcome, interventions within this component were centered on the following two major outputs:

- Increased national capacity to generate, analyse and disseminate gender-disaggregated data for policy formulation, planning and programming monitoring and evaluation; and

#### 4.2.1 Increased National Capacity to Generate, Analyse and Disseminate Gender-Disaggregated Data

Efforts to attain this goal entailed implementing a wide range of interventions by the participating partners as outlined in Table 2. These interventions were guided by specific
indicators. The interventions that were implemented included strengthening the capacity of the National Statistics Office (NSO), the Ministry of Development Planning (MoDPC) and the Demography department at the Chancellor College of the University of Malawi, as well as facilitating the establishment of a national statistics system.

**National Statistics Office**

Capacity enhancement for the NSO followed the broad definition of capacity building which encompasses human resource development through skills and knowledge enhancement. Other aspects of capacity development for this strategic population and development institution were providing equipment to strengthen organisational capability to effectively undertake specific activities, such as the 2008 National Population and Housing Census (PHC). Human resource development included the involvement of key NSO staff in both short- and long-term internal and external training programs. In this regard, various officers in different roles at NSO were trained or refreshed on relevant concepts and were involved in workshops with the goal of imparting, consolidating and harnessing their skills to improve the quality of interventions. For instance, some staff at NSO were trained and equipped with Geographical Information Systems (GIS) advanced demographic skills, while others had their population analytical skills further sharpened and enhanced through a long-term Master’s degree program. As indicated earlier, staff members were involved in both internal and international courses on a wide range of topics, all of which were aimed at enhancing their skills in order to further their capacities.

Further, through the 6th Country Programme, NSO’s demography staff were also trained and equipped with skills in the utilisation of STATA, which is quantitative data analysis software. These skills were very critical at the post-PHC stage, during which census data were analysed. As well, more staff from NSO were externally trained and equipped with skills in data editing and analysis. This entailed courses on the CSPro Programme as well as data editing.

Other forms of capacity building for the NSO were focused on ensuring that it was equipped to effectively undertake the 2008 PHC. The importance of an effective PHC process cannot be overemphasised, as the PHC provides data and information which is vital for designing, programming, implementing and making decisions on issues affecting all sectors of the economy. In this context, technical support was provided to NSO, which included hiring a Census Chief Technical Advisor as well as a Census Finance Officer. In addition to these experts, people were also hired in other areas to increase capacity for managing related processes, ensuring timely completion of the census, and producing vital reports for the PHC.

Moreover, UNFPA also provided equipment including computers, vehicles and other supplies, which facilitated the smooth undertaking of the 2008 PHC. Financial resources were also mobilised and provided to NSO for the 2008 PHC, amounting to slightly over 18 million USD. New technological equipment was also provided to the NSO allowing data to be scanned instead of manually-entered. This was vital to expediting the post-data collection processes, which facilitated the timely release of the PHC results.

Overall, the increase in capacity for NSO enabled the successful implementation of the 2008 PHC. So far, NSO has released some of the 13 expected thematic reports and these have been disseminated for use by different players in all sectors of the economy. These thematic reports are being utilised by government, development partners, NGOs, academicians, the faith
community and a wide range of other players in all sectors of the economy in designing, planning and implementing various initiatives aimed at improving the socio-economic condition of the country.

**Population and development policy**

The programme also set out to facilitate the finalisation of the national population and development policy by strengthening national capacity, especially that of the MoDPC. By the midterm evaluation of the 6th CP, the GoM through MoDPC, with enormous technical and financial support from the UNFPA, developed a revised population policy based on the results of the 2008 PHC and submitted it for cabinet approval. The PHC data were able to be successfully utilised to refine the population policy because of the skills that key and relevant staff in MoDPC acquired through the 6th CP. The policy is now ready for presentation to the cabinet which is chaired by the State President of the Republic of Malawi. Once the policy is available, various sectors of the economy will be appropriately guided and informed in designing, programming, monitoring and evaluating different socio-economic programs. Further, as the government institution responsible for coordinating the implementation of the 6th CP, many officers within the MoDPC have been trained and equipped with various skills such as integration of population issues into development plans. These skills have further been transferred by the Ministry to sectoral and district planners. This has been paramount to ensuring the successful implementation of the 6th CP, thereby enabling it to achieve most of its set targets.

**Effective integration of population issues into the MGDS and MDGs**

Since the 6th CP midterm evaluation, three surveys have been conducted on migration, Gender Based Violence (GBV) and Multiple and Concurrent Partnerships (MCPs). The findings of these surveys have played a critical role, allowing planners to account for population and gender dynamics in different development programmes, ensuring equal targeting of services so as to provide equitable access to benefits.

The Malawi Demographic Health Survey (MDHS) was conducted in 2010 and results expected to be released early 2011. The 6th CP P&D team coordinated the survey, which provided an opportunity to ensure that social population and development issues were part of the survey. Such issues related to HIV testing, young adults, fistula, domestic violence and GBV. This was vital, as it helped to establish background information on these issues and increase their prominence in terms of resource allocation, programming implementation, monitoring and evaluation. In addition, the inclusion of such issues will be fundamental to sensitising members of institutions such as the National Assembly, who in turn expedite laws and participate in other critical decision making processes.

The 2008 PHC results were widely disseminated at the national, district and community levels for development planning and implementation purposes. The data strengthened the capacities of people at each of these levels to integrate population data in development design. For instance, with support from the 6th CP, NSO facilitated the capacity strengthening of district-level planners and other key experts, traditional authorities and cadres of community-level leaders. This was pivotal for creating new awareness in these groups on the need to utilise population data in the design of interventions.
Advocacy for use of disaggregated data in policy creation

As indicated earlier, the successful undertaking of the 2008 PHC has been critical to other development processes, including refinement of the population policy and development of Malawi Growth and Development Strategy II.

Several advocacy processes have been put in place to ensure the continuous utilisation of population data in development design, planning and implementation. These processes engage relevant parliamentary committees, policy creators, decision makers and other strategic people. For instance, the University of Malawi and officials from the MoDPC held debate and advocacy forums which engaged several high profile and prominent members of Malawian society, ensuring consideration of the development and population data. In addition, public lectures were also conducted which facilitated dialogues on development and population issues by impressing upon decision makers the importance of using population data when formulating policies and development programmes, so as to maximise their effectiveness.

Further, the P&D component of the 6th CP also facilitated capacity strengthening for partners through printing and producing various materials on population issues. As stated earlier, such trainings have been vital in helping organisations such as the NSO to ensure timely production of thematic population reports which have been disseminated across the country. Furthermore, the staff in the MoDPC appropriately refined the population policy by integrating issues as revealed by the 2008 PHC into the policy, thereby increasing its relevance.

Strengthening human resource capacity for conducting research on population issues and to implement the population policy

The 6th CP has been essential in assisting the University of Malawi (through the Chancellor College) to attain its core mandate of training and producing demographers and population experts in the country at both the undergraduate and graduate levels. Also, as indicated earlier, the Chancellor College has also directly undertaken primary and operational research studies or contributed to research studies for other institutions and organisations. Further, the college has provided advisory services on population issues to the government and other stakeholders. The 6th CP, through the P&D component, was critical to enabling the college to achieve these aspects of the mandate. Over the period of the CP, an estimated 350 Malawians were ushered into the economy with skills in minor contexts, and they have been providing expertise to the government, international development agencies, NGOs and other relevant institutions. Also, an estimated 125 experts majoring in population and demographic issues were deployed into various sectors of the economy to provide expertise in demography and population issues and have been engaged in programs that benefit the poor to access sexual reproductive health services. The country continues to benefit from their expertise.

However, there is a need to double efforts aimed at determining the capabilities of these experts by designing a feedback system on the appropriateness of the skills they acquired at the college. This would also provide evidence of the revolution that is taking place within the country’s training institutions, in which various academic programmes are being reviewed with the goal of incorporating other emerging issues into their curricula in light of rapid development in the country.
The college, through the Department of Population Studies (DPS) and the 6th CP, is effectively equipped to provide service training to population professionals from various sectors of the economy. Further, the imminent approval of the National Population Policy will allow coordinated efforts in monitoring its implementation. In this regard, processes are being developed to strengthen capacity so as to ensure that the implementation of the policy is well monitored. Human resources, which until recently remained a constraint to the effectiveness of the MoDPC, are currently being enhanced by the inclusion of population experts in appropriate departments. Additionally, existing staff are being trained and equipped with skills in population policy monitoring.

4.2.2 Increased Availability of a National Gender-Disaggregated Database for Monitoring and Evaluation

Increasing the availability of a national gender-disaggregated database for monitoring and evaluation of national strategies for economic growth and poverty reduction constituted one of the outputs that were being pursued by the P&D component. In achieving this output, several strategies were earmarked for implementation, the majority of which significantly contributed to economic growth and poverty reduction as follows:

**Strengthening integrated management information systems**

The component was committed to facilitating the establishment of a national Information Management Information System (IMIS) so as to improve monitoring of economic growth and reduce poverty. The IMIS is yet to be established, but substantial progress has been made in preparing for the development of the IMIS and plans have been formulated for implementing this activity in 2011 before the end of the 6th CP.

The 6th CP was fundamental in updating and redeveloping the Malawi Social Economic Database (MASEDA). MASEDA was updated with new indicators and data based on the 2008 PHC. Thanks to support from the 6th CP and other development partners, the MASEDA is now a web-based database which can easily be accessed throughout the country and elsewhere containing all of the socio-economic information for Malawi that is necessary for programming and designing development agendas. The MASEDA will be widely disseminated and will become an important platform for involving various key players on population and development issues in Malawi.

However, there is a need to ensure that the MASEDA is further developed based on user feedback on usability, relevance and other aspects. This may involve providing an interactive function on MASEDA’s website so that people can leave comments and ask questions. It will also enable the caretakers of the MASEDA website to respond quickly to user queries. All of these efforts would enhance the utility of the MASEDA by ensuring that various key players are provided with current information on various socio-economic issues and the latest efforts aimed at ensuring economic growth and poverty reduction in the country.

**Strengthening partnership for monitoring and evaluation**

The implementation of this strategy entailed supporting the national M&E plan by integrating population indicators. In this regard, indicators related to population and development were designed and incorporated into the M&E plan and have since become integral. This is essential,
since population trends and issues of growth and concentration, among others will now be sufficiently monitored and will become part of the development agenda of the country from this point forward.

**Challenges**

In the context of the P&D component, several challenges constrained the implementation and completion of some activities which subsequently affected the attainment of some of the outputs. Key challenges included:

- Weak human resource capacity with the relevant department in MoDPS, which affects the coordination and monitoring of activities. This potentially impacts the quality of interventions, as the appropriate government arm responsible for co-managing the programme does not do its work sufficiently. The consequences are far-reaching, not only for the P&D component, but for the 6th CP as a whole.

- The Population Department at Chancellor College is heavily understaffed due to a high attrition rate. This affects the successful implementation of 6th CP-related programs.

- The delayed approval of the population policy is derailing the implementation of other activities that are dependent on it, thereby contributing to underachievement of the P&D component.

- Population interventions do not have a direct impact, but facilitate goal attainment in other areas. This calls for creative ways of identifying the direct impact which is created by P&D work.

**4.3 Gender**

The goal of the UNFPA gender outcome area was to achieve gender equality and to empower women by strengthening legislative frameworks for gender equality and equity and building capacity in gender analysis, with mainstreaming and budgeting as the outputs. This CPAP outcome directly contributes to the fifth UNDAF outcome of enhancing good governance and gender equality and taking a rights-based approach to development. Apart from the contribution that the CPAP is making to achieve the UNDAF outcomes, it is also making important contributions in the implementation of the NRGBV which is one of the national instruments developed by the Government of Malawi through the MoGCCD. Most of the strategies that were developed to achieve the CPAP gender outcome have a direct link to the action plan for combating GBV in Malawi.

Output achievements were to be tracked through the following indicators: reviews of laws and bills that enhance gender equality and equity, training of law enforcement officers on gender-related laws, training of government departments and other stakeholders on gender analysis, mainstreaming and budgeting, and monitoring government departments that exercise engendered budgeting. In relation to the aforementioned indicators, the CPAP also envisaged an increase in the percentage of women in decision making positions including the National Assembly, a reduction in number of GBV cases, and a reduction in the number of persecuted GBV cases disaggregated by gender.
This section provides information on the activities undertaken by UNFPA implementation partners to achieve the two CPAP outputs related to the gender outcome while addressing the needs of the people of Malawi.

4.3.1 Strengthening the Legislative Framework for Gender Equality and Equity

The CPAP put strategies in place that contributed to goal achievement, which included creating awareness of gender-related laws and policies, enhancing the capacity of duty bearers on enacted laws and policies, building and strengthening partnerships for law reforms, changing harmful cultural practices, advocating for a more protective environment against gender-based violence, and domesticating international and regional instruments. In order to enforce these strategies, the implementing partners carried out a number of activities focused on civic education and community awareness on gender-related laws and GBV, empowering women concerning decision making through the 50/50 campaign, women’s rights, male involvement in combating GBV, the eradication of harmful cultural practices that influence violence against women and girls, and involvement in national and international activities such as 16 days of activism.

In creating awareness on gender-related laws, the CP supported community awareness programmes by the Malawi Law Commission (MLC) on laws such as the PDVA, which had been enacted by Parliament, as well as the Gender Equality Statutes, Marriage and Family Relations and Human Trafficking Bills, which are in report form. Apart from the (MLC), the NGOGCN has also been active in empowering women by providing education on decision making through the 50/50 campaign as well awareness of gender-related bills related to wills and inheritance and the gender statutes.

Capacity enhancement of duty bearers was facilitated through civic education programmes in the districts. This civic education was aimed at civil servants, traditional leaders, and CBO members. The law commission played a great role in conducting this activity.

Community lobbying against harmful cultural practices that influence violence against women, especially in relation to HIV and AIDS, has also taken place. In addition, community awareness campaigns on GBV, women rights, male involvement in curbing GBV, establishment of CAGs and CVSUs have been implemented.

Analysis of the activities has shown that progress has been made towards outcome achievements at both the national and community levels.

National level achievements

A number of achievements have occurred at the national level in relation to strengthening gender-related legislation.

- UNFPA has facilitated the development and production of the NRGBV by providing financial and technical support to activities ensuring the creation of a protective environment against GBV and domestication of international and regional instruments. The NRGBV aims to provide the framework for fighting gender-based violence. This document was drafted with the goal of streamlining the planning process and encouraging
implementers, service providers and donors to combine resources and strengthen existing synergies between current and existing initiatives on GBV (NRGBV, 2006).

- UNFPA has provided financial support for the mapping exercise on GBV stakeholders in Malawi. The mapping exercise report provides various intervention stakeholders with information on how to facilitate coordinated GBV implementation, including gaps and best practices in GBV programming.

- UNFPA has supported the lobbying and enactment of gender-related laws including the PDV Act and Child Protection Bill, which have been enacted and passed by Parliament, respectively. Other bills such as Wills and Inheritance (estates), Marriage and Family Relations and Human Trafficking are still in report form, however national and community awareness of these bills is currently being cultivated with support from UNFPA.

**Community level achievements**

A number of other achievements have also occurred at the community level. Some major ones include:

**Increased awareness of gender-related laws**

Community awareness meetings and civic education programmes on gender-related laws have enhanced the knowledge base of community members, traditional leaders, law enforcers and CBO members regarding issues such as the PDVA, Child Protection Bill, Marriage and Family Relations Bill, Wills and Inheritance, Gender Equality Statutes, and Human Trafficking Bill. The MLC conducts civic education on the above gender-related laws for traditional leaders, CBO representation, the police (prosecution and VSU) and social welfare in nine districts of the country. Despite the fact that only the PDVA and the Child Protection Bill have been enacted and passed by the National Assembly and the rest of the bills are still in report form, the response from community members to information regarding the laws has been positive.

The target for the CP was to have four bills enacted by the end of fourth year of the programme. Although, only two laws (the PDVA and the Child Protection Bill), have been enacted, substantial progress have been made towards the enactment of more laws such as the Wills and Inheritance, Marriage and Family Relations, Human Trafficking and Gender Equality Statutes Bills. Already, two bills (the Gender Equality Statutes and Human Trafficking Bills), have been proofread and reviewed by key players. The enactment of these bills will have profound benefits for the nation. Some of the benefits will include a woman’s right to access family assets after the death of her husband. The Gender Equality Statutes bill will ensure that there is equal accessibility for both men and women to productive resources, financial assets and other services without regard to gender.

**Enhanced capacity of duty bearers on enacted gender-related laws**

There has been increased civic education for duty bearers on enacted gender-related laws and those that have yet to be made official. The 6th CP has enhanced the capacity of magistrates and police in both prosecution and victim support units through capacity building.
This capacity building has provided law enforcement officers with an opportunity to understand the laws and to understand how they can use them to address issues of domestic and gender-based violence. For legislation that has yet to be officially enacted by the National Assembly, civic education programs have helped the law enforcement community understand pertinent issues and how the enactment of these laws will ensure decreased violations of human rights.

The capacity building sessions involved a total of 105 duty bearers (magistrates and police) from 2008 to present, as shown in Table 7 below.

**Table 7: Number of Duty Bearers Trained**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Duty Bearers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>25</td>
</tr>
<tr>
<td>2009</td>
<td>25</td>
</tr>
<tr>
<td>2010</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
</tr>
</tbody>
</table>

In order to enhance the capacity of the duty bearers, two study tours on legislating gender-related laws were also conducted in Mauritius and Namibia. Best practices on how the laws are implemented were learned and will be adapted to the Malawian context.

**Reduction in number of GBV cases and increased reporting**

The number of GBV cases has decreased because people have become empowered to handle cases at the community level through establishment of Community Action Groups (CAGs). CAGs have been empowered through training in GBV and hence they have the capacity to counsel both victims and perpetrators. The reduction in the number of cases is a result of changed behaviours and attitudes among perpetrators and PDVA awareness. Awareness meetings have also enhanced an increase in the number of reported cases, as people have become aware of human rights, the rights of women, and education on how to identify violent acts or behaviours.

**Improved representation of women in politics**

The CP supported programme on increasing women participation in politics and decision making processes. The 50/50 campaign, which has been championed by the NGOGCN among others, has the goal of increasing the number of women in decision making positions. According to the PPE 2009 report, the percentage of women parliamentarians has risen from 14% (27) in previous Parliaments to 22% (43) of all the seats in the National Assembly. One major achievement was the election of the first female Vice President of the Republic of Malawi.

**Increased awareness of the harmful cultural practices that influence GBV**
Establishment of CAGS in the communities by the NGOGCN in collaboration with the MoGCCD has assisted in spearheading activities aimed at reducing GBV and have enhanced linkages between GBV, SRH and HIV and AIDS. The CAGs are comprised of community leaders, police officers in VSU departments, health surveillance assistants, community development assistants and members of CBOs. The presence of diverse professionals in these CAGs has been critical to ensuring proper and informed integration of GBV, SRH and HIV issues into a multi-issue package of preventive services, thereby addressing all relevant issues at once.

One of the most prominent activities influencing community awareness is lobbying for the modification of cultural practices that influence GBV. CAGs, in collaboration with other NGOs, have campaigned against sexual cultural practices which include chokolo (wife inheritance), chimwanamayi (wife exchange), chijula nyumba (sex with virgins when they attain puberty), and kupimbira (giving girls in marriage as debt payments to wealthy, mostly elderly people). Though some of these cultural practices are being modified and in some cases being eradicated, there remains a need for more awareness to continue influencing the modification of some harmful sexual cultural practices that are still being practised in some impact areas of the program.

In Rumphi district, for instance, where the culture denies women to have access to land because of the lobola tradition, changes are being made through community awareness and training campaigns conducted by the Rumphi Lekani Nkhaza network, an establishment of the MoGCCD through the Rumphi Social Welfare office. The network has been vital for spearheading community awareness and education processes that have been pivotal to the community decision to modify the cultural practice.

**Increased involvement of men in combating GBV**

The CP has engaged men to join the fight against GBV. Groups of men have been formed and trained in six districts of the country: Dowa, Mzimba, Chitipa, Neno, Rumphi and Blantyre. In each district two TAs participate in men to men initiative in which 20 men are identified from each of the TAs to undergo training and spearhead efforts in addressing GBV issues. This translates to the existence of 40 appropriately trained men from each of the districts resulting in a total of 240 men with skills in their roles in the fight against GBV, SRH and HIV prevention. These male groups have been at the forefront, engaging men in community awareness meetings and taking part in the counselling of victims and perpetrators of GBV. This initiative has improved the participation of men at GBV community awareness meetings, as they are addressed by other men instead of women, which was the trend in the past.

The table below shows the case of Kanengo Police Station in which GBV cases are steadily declining due to the active participation of men in the fight against GBV.
Table 8: Cases of GBV at Kanengo Police Station in Lilongwe

<table>
<thead>
<tr>
<th>YEAR</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
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<tr>
<td>January</td>
<td>38</td>
<td>44</td>
<td>52</td>
<td>41</td>
<td>39</td>
<td>35</td>
<td>33</td>
</tr>
<tr>
<td>February</td>
<td>41</td>
<td>49</td>
<td>61</td>
<td>68</td>
<td>35</td>
<td>33</td>
<td>31</td>
</tr>
<tr>
<td>March</td>
<td>52</td>
<td>38</td>
<td>43</td>
<td>49</td>
<td>36</td>
<td>40</td>
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<tr>
<td>April</td>
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<td>49</td>
<td>63</td>
<td>38</td>
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<td>May</td>
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<tr>
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<td>72</td>
<td>34</td>
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<td>87</td>
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<td>45</td>
<td>42</td>
<td>39</td>
</tr>
<tr>
<td>August</td>
<td>90</td>
<td>35</td>
<td>84</td>
<td>58</td>
<td>47</td>
<td>44</td>
<td>41</td>
</tr>
<tr>
<td>September</td>
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<td>56</td>
<td>32</td>
<td>51</td>
<td>44</td>
<td>40</td>
<td>36</td>
</tr>
<tr>
<td>October</td>
<td>63</td>
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<td>37</td>
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<td>84</td>
<td>91</td>
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<td>TOTAL</td>
<td>830</td>
<td>706</td>
<td>741</td>
<td>663</td>
<td>452</td>
<td>382</td>
<td>360</td>
</tr>
</tbody>
</table>

**Increased support to GBV survivors**

The establishment of district CVSUs by UNICEF, and supported by UNFPA, contributes to the provision of psychosocial support to GBV survivors. This support is provided in the form of counselling for victims and perpetrators, provision of temporary shelter, and financial support for victims who must return to their original homes. The CVSUs were trained to provide counselling in cases that do not require police interventions. However, in grave cases, the CVSUs are responsible for reporting matters to police VSUs, who proceed to refer the cases to courts if perpetrator behaviour does not change or if there is loss of life or bodily injury.

The 6th CP has supported the MoGCCD in training 120 survivors in psychosocial support (PSS) from 2008 to the present (40 survivors a year). The survivors are given life and survival skills training and counselling. After the training, the survivors are sent back into their communities and contacted later to assess how they are being reintegrated into their communities. In the same light, service providers (police, social welfare and VSU) have also been trained in PSS to ensure effective service provision to the survivors.

**Increased participation of churches in combating GBV**

The 6th CP has contributed to increased participation of churches in the fight against GBV. A National Plan of Action (NPA) against GBV has been developed by churches to encourage and support an active response towards social transformation of the communities and churches themselves. It is expected that the implementation of the NPA will, among other things, contribute to: the integration of GBV issues into Christian education, the adoption of measures to address GBV within church structures, the attainment of leadership positions by women, and provision of transforming counselling and care to GBV victims. The NPA will ensure that
churches take an active role in ensuring that women are living in protective environments that allow them to contribute to development activities without fear of prejudice.

Additionally, church teachings have been reviewed, and a generic GBV teaching manual for Christian formation has been developed. The development of the manual will ensure that the church has people who understand gender issues and who will take up the role of training other members of the church them, including GBV. The training of the Christian community will also reduce the marginalisation of women in decision making positions and allow them to become active members in ministry.

The CP also supported TOTs for clergy on GBV counselling. The trainings were conducted at regional levels where a total of 67 clergy were trained with a distribution of 25 in the south, 20 in the north and 22 in the central region. These clergy will be involved in providing counselling services to GBV victims and perpetrators.

The CP has further supported the church in advocacy activities through the media. Radio jingles are being run on Zodiak radio and Malawi Broadcasting Corporation (MBC) about four times a week and are scheduled to run for six months (July 2010 to January 2011). These jingles complement four Pamajiga radio drama series being produced by MBC and two panel discussions on Zodiak. These advocacy activities have solidified the role of the church in reducing GBV and also created awareness among the church faithful to participate in the activities that lead to the fight against GBV.

Aside from these major achievements, gender-based violence awareness and training have also contributed to the following achievements:

- There has been a notable increase in knowledge on matters of human rights, women’s rights, and gender in general.
- Women have the right to make decisions on the utilisation of productive resources and family finances.
- Both women and men can now assume responsibility for matters that were previously culturally-sanctioned for men only.
- Awareness campaigns on GBV have allowed youths to change their behaviours and attitudes.
- Women are now running their own businesses such as fritter making.
- Youths are involved in different activities such as traditional dances that disseminate messages aimed at reducing GBV.

4.3.2 Capacity in gender analysis, mainstreaming and budgeting strengthened

This output was set to be realised by enhancing stakeholder capacity in gender analysis, mainstreaming and budgeting, and strengthening the collaboration and monitoring of gender analysis and mainstreaming. In order to contribute to the achievement of these strategies, the 6th CP built the capacity of CSOs and relevant government personnel in these areas.
UNFPA has been working in collaboration with the MoGCCD to build the capacity of different institutions to ensure that gender is being mainstreamed in all developmental programmes along with requisite budgets.

UNFPA has supported the training of 38 CSO members in gender analysis and mainstreaming to enhance the skills of CSOs in gender-sensitive programming. These CSO members complemented 15 officers from three district assemblies that were already trained in gender analysis and mainstreaming by the MoWCD. The district assembly officers that were trained included M&E officers, planning officers, district AIDS coordinators and community development officers.

Following the establishment of the public sector GFP, quarterly review meetings were instated to enhance coordination and networking as well as dissemination of lessons learned to the different public sector ministries coordinating gender mainstreaming. UNFPA has supported the MoGCCD in training 28 focal persons (20 female and 8 male), who have acquired skills which are being used to facilitate meaningful project design, implementation and monitoring of gender-related activities by their organisations. In addition to this, a needs assessment was conducted to provide the basis for the establishment of gender posts in the public sector. However, the results of the assessment have yet to be adopted by the public sector.

The MHEN has been conducting advocacy activities to ensure a gender-responsive 2010-2011 budget. These advocacy activities evolved from the findings of the gender-sensitive budget analysis conducted in four districts of the country (Salima, Ntchisi, Chitipa and Zomba). Various advocacy activities with policy makers, including national interface meetings with the health parliamentary committee, HIV and AIDS committee, parliament women’s caucus, finance committee, and decision makers from MoH and MoGCCD, district interface meetings with DHOs and DEC members, press briefings and panel discussions have been conducted to create awareness on the importance of developing a gender-sensitive national budget.

The health sector advocacy work has improved relationships between communities and health workers to better understand the current health issues faced by service providers and users, such as the issue of inadequate health workers in the hospitals. It should be noted, however, that although there have been advocates for a gender-sensitive budget, the advocacy was for the health sector only. There is, therefore, a need for more advocacy activities in all public sectors to ensure that all budgets are gender-sensitive. In order to enhance stakeholder capacity to develop gender-responsive budgeting (GRB), UNFPA also supported the training of 16 CSOs in GRB advocacy. Furthermore, 45 local leaders from five districts have been trained in participatory gender-sensitive budget formulation and tracking. These leaders are training other community committees and community members on GRB.

Challenges

There are a number of challenges impeding the successful implementation of gender-based violence programmes, as outlined below.

**Inadequate resources for monitoring GBV programmes**

Stakeholders carrying out gender advocacy activities often discuss a lack of resources for monitoring the programmes, and in some cases, for implementing the programmes themselves.
Community awareness campaigns have been affected by resource availability, and as a result, some communities do not have access to adequate information on gender issues. Lack of adequate resources has also affected the advocacy work in other public sectors to ensure that all budgets are gender-sensitive.

**Delays in funding disbursement**

Delays in funding disbursements have affected the implementation of activities. Community awareness programmes on gender-related laws, for instance, have not been conducted for all districts because the funding for this activity was initiated very late in the year when the new annual plan was being developed. This has therefore created a knowledge gap among districts in terms of gender-related laws.

**Lack of proper rehabilitation services**

Rehabilitation services are one of the challenges facing the successful implementation of gender-based violence reduction activities. Due to a lack of resources, most victims, especially victims of economic abuse, are not provided with any skills that would enable them to be economically independent. Results from focus group discussions indicated that most victims are offered counselling as the only way to rehabilitate themselves. This was reported to have been one of the reasons most victims remain at the mercy of their abusers because they do not have any skills to engage in income generating activities that would enable them to be economically empowered.

**Other challenges**

- Long distances are being covered by volunteers in CAGs and CVSUs who reach out to victims/survivors to attend scheduled meetings, resulting in many dysfunctional groups.

- There is a lack of structures for CVSU service operations. Most structures are offered by individuals and poorly-built; very few CVSU’s have their own structures.

- Some deep-rooted cultural practices (e.g. kupimbira in Karonga) are difficult to ameliorate in the short-term. More concerted efforts are required if success is to be achieved in this area.

- Though reporting guidelines for GBV partners were developed to ensure uniformity in reporting, most stakeholders are not following the reporting format and this has contributed to the absence of gender-disaggregated data on reported GBV cases, even at the NGOGCN.

- An absence of networks for other public sectors has resulted in little or no advocacy for GRB formulation and this has affected equal accessibility to services by males and females.
5 MONITORING AND EVALUATION

UNFPA has a well-developed and articulated monitoring and evaluation system for all levels of the 6th CP. A logical framework matrix, which defines outcomes, outputs, strategies and programmatic activities, is also appropriately in place. A monitoring and evaluation officer was recruited in 2009 to manage M&E processes; that person works closely with programme officers in the various divisions and the IPs. Arrangements for monitoring the implementation of the CP have been put in place, with the MoDPC population department being one of the responsible agencies. Progress reports have been periodically prepared through a monitoring system which is limited in terms of its correspondence with indicators, as outlined in the CPAP tracking tool. There is, however, evidence of regular annual progress review meetings involving all partners. There is also evidence of partner meetings among those working within the same outcome areas, although these are not institutionalised and happen intermittently.

Prior to the arrival of the M&E officer, M&E lacked adequate coordination and data management was quite a challenge. In addition, the entire monitoring system for the 6th CP is somewhat uncoordinated and there is no proper correspondence among data from the IPs and the M&E framework at the UNFPA CO level. Although attempts have been made by the CO to define various indicators at all levels of the logical framework based on the CPAP, such indicators are not clearly developed by key implementation partners in the 6th CP. While programme officers develop quarterly reports for activities implemented within their divisions, the reports lack adequate information on general performance-based indicators, as IPs do not provide the necessary data with which to effectively monitor performance. This was evident during the evaluation, when data was difficult to obtain at from IPs, making it difficult to obtain well-defined data specifically for IPs at the CO. The M&E officer alluded to the same challenge, although commendable efforts have been made to correct this; data management seems to have improved since the new M&E officer has been brought on board.

Unless improvements are made to synchronise indicators at the CPAP and IP levels, the M&E system limits the ability of the programme to provide proper performance data for the each of the outcome areas. The synchronisation of indicators at the CPAP and IP levels is essential for determining meaningful information regarding implementation performance and progress towards achievement of outcome and output indicators.

In summary, a carefully planned monitoring and evaluation system for the programme is in place along with an M&E expert who coordinates M&E activities. However, while the M&E system contains all of the important elements including indicators, definitions of indicators, data sources, data collection methodology and means of verification for various achievements, there is a need to synchronise the monitoring indicators and the performance indicators at the CPAP level with those at the IP level.
6 LESSONS LEARNED

Following are lessons based on the evaluation findings and discussions with implementation partners. These lessons are being documented to facilitate learning as well as inform the future design of subsequent CPs, in particular the 7th Country Program. It is therefore of significant importance to critically analyse and learn from them before developing the subsequent program.

- Any expansion of work, especially in terms of geographical areas of focus, must be preceded by a rigorous analysis of a wide range of factors, such as the consequences of the expansion on resource availability and adequacy of technical support. It must also be considered that preparatory work for programme implementation should be completed well in advance to ensure that during the actual implementation, logistics do not negatively impact the interventions.

- When programme delivery is done through partners, adequate synergies on various systems such as M&E must be present to ensure correlation between reports from programme anchors and partners, smoothing the data management and reporting process.

- The inclusion and targeting of young people in any development intervention is paramount for success, sustainability and generational memory, thereby contributing to the positive transformation of societies. The young characteristic of the Malawi population therefore necessitates that young people should form the major focus of most of the interventions.

- Institutional capacity development for partners and communities alike is fundamental to cultivating effectiveness as well as sustainability.

- Institutional structures and systems are very important in the successful implementation of the CP. More specifically, the inadequate capacities of government ministries and civil society implementation partners in terms of human resources (low numbers and skills) and management systems (coordination, policy frameworks and financial management) hampered the implementation of the CP.

- Technical assistance and advisory services remain a critical strategy for bridging human resource constraints while enhancing the capacity of existing staff. The presence of external experts in the CO is of fundamental importance and adds a lot of value to the quality of the CPs.

- It is possible to enhance the implementation of the Country Programme by identifying the best-positioned implementation partners, thereby widening the scope of interventions. A substantial increase in the number of implementing partners played an important role in expanding the coverage of the CP.

- Strategic partnerships with government, parliamentarians, NGOs, FBOs, other UN organisations, and the media are very important when advocating for population and development issues.
• Working in partnership with other UN agencies and other bilateral partners facilitates the implementation of key activities by using their competitive advantage and leveraging resources.

• Cultural sensitivity is very important in the design and successful implementation of CPs, especially gender equality, SRH, and HIV prevention programmes. In this regard, the need to acknowledge and respect the role of traditional leadership and associated structures cannot be overemphasised.
7 PROGRAMME IMPACT

7.1 Overall
It is clear from all implementing partners, communities and key informants that the 6th CP has made tremendous strides in contributing to the development goals and objectives of Malawi, hence contributing to the quality of life of her people, especially youths, mothers and the rural communities who are targeted through this program. The 6th CP moved swiftly to begin addressing the SRH, HIV prevention and gender equality needs of the societies of Malawi. The 6th CP has made enormous contributions at all levels in the country (i.e., national, district and community levels). For instance, at the national level, the 6th CP has mobilised resources and provided the necessary capacity and technical support to facilitate the development of various policy frameworks which will guide a focused implementation of different development agendas. At the community level, the 6th CP has contributed to a reduction in youth pregnancies, thereby impacting many aspects of their lives. They remain in school and have been able to avoid contracting STIs, including HIV. Due to UNFPA efforts in maternal mortality reduction, some deaths have been averted, and mothers can now live and contribute to the development of their households and the country at large in one way or another. The sections below provide outlines of a few of the many impacts that have been brought about by the 6th CP.

7.2 RH and HIV Prevention

Reduction in maternal mortality rates
MMR has decreased from 800/100 000 live births in 2004 to 500/100 000 (2010 DHS) due to an increase in the number of deliveries by skilled health attendants and reorientation of TBAs to new roles. UNFPA has contributed to the reduction of MMR due to its support of activities implemented through its partners. These activities include training skilled attendants in obstetric life saving skills, reorienting TBAs into new roles, encouraging community participation in MNH, training family planning providers in the communities like CBDAs and HSAs, and providing contraceptives like DMPAs, Oral contraceptives and condoms. In addition, UNFPA has contributed to a reduction in MMR by reducing teenage pregnancies- and promoting youth-friendly health services as well as providing radio communication systems and bicycle ambulances

Increased use of antenatal care
Use of antenatal care services has increased due to community interventions related to MNH and community involvement in safe motherhood through different community committees such as safe motherhood committees, which ensure that all pregnant women attend antenatal clinics and deliver at hospitals.

Increase in births with skilled attendants
The percentage of births with skilled medical attendants rose from 54% to 65%,- an achievement that UNFPA has contributed to by providing training in obstetric life saving skills and basic infection prevention equipment. Traditional leaders have also mobilised communities to ensure that all pregnant women deliver at health facilities. The 6th CP has assisted in the construction of waiting shelters like the one at Mkanda health centre in Mchinji.
Increase in CPR
UNFPA has contributed to an increase in CPR from 28% to 41% % DHS by training providers at district hospitals, health centres and in communities on family planning, in addition to the methods used by CBDAs and HSAs.

Decrease in fertility rate
The fertility rate has decreased from 6.3% to 6.0%, which UNFPA has contributed to through various interventions at both the facility and community levels in family planning.

Collectively, the activities that were implemented for the achievement of the two outputs above have contributed to increased access to high-quality sexual and reproductive health information and services in the country. Central to this contribution are: (a) an increase in the capacity of government and civil society institutions to increase the availability of sexual and reproductive health services through financial and material support provided by UNFPA; (b) an increase in the availability of behaviour change communication programmes for young people, with an emphasis on HIV;

Improved Prevention and Management of Fistula
In relation to prevention and management of Obstetric Fistula, the 6th CP has been fundamental for the strides which the country has achieved in managing this condition. In this regard the program facilitated the increase of appropriate OF management skills through the provision of skills to about 30 medical personnel (Clinical Officers & nurses). The enhancement and provision of the skills has been essential in facilitating the repairing and management of fistula. Women’s lives have been restored as they are able to care and provide for the ir families and some of them can have children again as they so wish.

7.3 Population and Development
In respect to the population and development outcome, the 6th CP made the following contributions among many others that may not be directly attributed to this component:

- Increased capacity among various professionals within the GoM, which is enabling them to plan and appropriately target communities with development interventions.
- Provided equal access to higher education, as the government is able to use current population information when selecting students for admission to public universities. This ensures that the eventual benefits will be appropriately distributed throughout the country.
- The upcoming population policy, made possible largely by the support of the 6th CP, is anticipated to further enable informed decisions in development planning as well as contribute to increased dialogue on the need to check population growth to reduce the strain on the country's resources, since such strain further exacerbates poverty, deaths and general suffering of the population.
• Due to the availability of population data, institutions such as the National Local Government Finance Committee are able to equitably distribute financial resources for development of all districts in Malawi.

7.4 Gender

In the context of the gender outcome, UNFPA, through the 6\textsuperscript{th} Country Programme, has also made fundamental strides in contributing to gender equality and the empowerment of women. Some of the notable impacts include the following:

• UNFPA has contributed to a reduction in the school dropout rate through its activities related to youth RH and HIV prevention both in and out of school, and those who are out of school have been encouraged to re-enroll.

• Reduction and modification of harmful cultural sexual practices which affect both women and girls, such as early marriages and kupimbira (offering a female child in marriage to pay debts to a wealthy man, or pre-arranging a marriage in exchange for economic gains), chokolo (inheriting a woman after the death of a brother or an uncle) and chijula nthowa (sleeping with a girl soon after she reaches puberty).

• Increased care for OVC’s and other VGs via a community-established CBCC through the District Assembly where OVC’s and other children are supported with education and food. The communities also assist the OVCs and other VGs by providing them with other needs such as blankets, food and clothes. This in turn reduces stigma and discrimination.

• Increased representation of women in politics such as in the Malawi parliament, as well as other decision making positions in various sectors of the economy, thereby increasing the potential for prioritisation of issues affecting women.

• There are reported reduced incidences of GBV in one project supported by UNFPA, due to increased awareness of women and the wider communities to report on any forms of GBV.

• Facilitated the availability of appropriate legislation which provides for the protection and respect of human rights of the people of Malawi, especially the vulnerable.
8    SUSTAINABILITY

The notion of sustainability within the 6th CP was critically considered within the context of the programme management cycle (i.e., design, planning and implementation on one hand, and the organisational (IP) level on the other). Organisational sustainability is a key outcome of capacity building efforts. Our understanding of the meaning of sustainability in the context of this evaluation was based on an understanding that has evolved over a period of time due to empirical evidence of development and social issues. Originally, we understood sustainability in terms of the continuity of project activities and benefits in the absence of external funding. Currently, more comprehensive and subtle definitions have emerged. In this evaluation, three distinct aspects of organisational sustainability were considered: technical sustainability, the ability of an organisation to provide technically-appropriate, state-of-the-art, high-quality services; management sustainability, the ability to plan and manage all aspects of the operations; and financial sustainability, the ability to generate sufficient resources. The generation of sufficient resources is central to supporting other aspects within the framework of our definition of sustainability. It is therefore imperative that local resource generation be emphasised, especially when UNFPA and external resources can become unpredictable and diminish quickly.

In this context, the evaluation noted that the 6th CP performed exceptionally well at ensuring the sustainability of implementation partners and benefits at the community level. IPs are actively involved in the development of annual plans, as the plans are developed during meetings which involve all partners. The only challenge was that at times, UNFPA staff members created preconceived interventions which were expected to be adopted by the partners. This limits the imagination and creativity of the partners; at times, they would like to develop interventions that respond to experiences during implementation without necessarily diverting from corporate objectives and outcomes, as outlined in CPAP. For instance, within the gender component, partners think that in order to increase the independence of women, the development of livelihood skills must be considered along with the promotion of related interventions. One way to address this would be to provide financial seed money to groups of women who wish to venture into small businesses (e.g., raising livestock), allowing them to increase their incomes and become independent from their violent husbands. Similarly, survivors of GBV could also be supported in similar manner so as to increase and sustain their rehabilitation as a complement to GBV counselling services.

In addition, the 6th CP provided for reasonable organisational capacity strengthening by providing equipment like computers, printers and fax machines, and international and internal training that increased the skills of many staff members. Training nurses is also an approach that will ensure the sustenance of different interventions. However, such training must be targeted rather than across the board. In this regard, the CP would need to train nurses on specific focus areas such as SRH and HIV prevention.

At the community level, there is evidence that the benefits of the project have been sustained beyond the life of funding support from UNFPA. In the village of Peter for instance, the village headman called a meeting of the different groups in the village once funding ended. The village as a group discussed and came up with an idea of writing their favourite health promotions and disease prevention messages on the walls of their houses. The idea was that should anyone
passing by be interested in the message on the wall, they could knock on the door and the owner of the house who chose that message could share more information on the topic. Below is a sample of a house with a message on it. Most of the homes in the village have different messages on their walls.

**Figure 2: Health and Hygiene**
In the photograph above, the message aims to educate members of the community on the need to wash hands after visiting a toilet, after changing a baby's diaper and before giving food to babies. This demonstrates one community's sense of ownership over health, hygiene and development initiatives that affect their own lives, which is a good measure of sustainability at the community level.
9 GENERAL CONCLUSIONS AND RECOMMENDATIONS

9.1 Conclusions

Generally, the programme has achieved most of its targets in all of its outcome areas and has contributed to the enhancement of lives for the people of Malawi by empowering leaders and wider target communities as well as the youth who constitute some of the fundamental targets of the program. The active participation of communities, especially men, in non-traditional areas such as reproductive health only underscores how the programme has impacted both males and females. In Mangochi, for instance, where programme implementation recently started in collaboration with the DHO at the District Hospital, men are actively involved in RH issues. It was discovered that men are taking leadership roles in family planning issues and encouraging women to actively engage themselves in issues related to family planning.

Further, the evaluation shows that a significant progress was made in achieving what was planned for the 6th CP. A few exceptions are earmarked for implementation in the final year of the 6th CP, such as the Information Management System at the MoDPC, which will be established in 2011. The release of findings from the Malawi Demographic and Health Survey, due to factors beyond UNFPA, is a key initiative that is behind schedule, but by all indications this will be achieved before the expiration of the 6th CP.

The gender component has made some progress in male involvement, and a reduction in GBV cases was reported by one of the projects, even though we were not able to determine the extent to which this is true for the country as a whole. There is increased representation of women in politics such as in the Malawi Parliament, as well as other decision making positions in various sectors of the economy, and this component has made invaluable contributions towards that achievement. In terms of reducing the incidence of GBV, increased community awareness, especially among women who report on any forms of GBV, has resulted in an increase in the number of reported cases. The major challenge, however, is the frequent withdrawals of reported cases among women for fear of imprisonment of their husbands, on whom they still depend for their livelihoods in the absence of livelihood improvement programs.

Notwithstanding any design and implementation challenges, the CP and CPAP were, in terms of the issues addressed, well thought out, and are still relevant to the goals and aspirations of the Government of Malawi in terms of population and development, SRH and HIV and gender.

9.2 Recommendations

9.2.1 CO and IPs

- Different groups of young people should be assessed in terms of SRH to inform new initiatives in service outreach and IEC. Efforts should be made to pilot a range of “access strategies” to accommodate disparities in access and acceptability across different social groups.

- The CO should make efforts to ensure that financial disbursements are made in a timely fashion to avert the effects of late disbursements on project implementation and potential
effects on the quality of interventions when activities are rushed in order to meet implementation deadlines.

- Mechanisms and operational guidelines should be devised to strengthen the participation and empowerment of the youth and target communities. Their input in all cycles of annual planning is important, as it facilitates responsive and targeted implementation of interventions. This also enhances relevance and increases response to emerging issues, since development is dynamic.

- Data management must be strengthened in order to ensure the immediate availability of data, which is important in determining a program’s status quo and facilitating decision making.

- Monitoring indicators must be synchronised between the CO and IPs, thereby increasing the programme’s ability to generate appropriate monitoring data and to facilitate informed assessment of progress towards the attainment of corporate programme indicators.

- The inculcation of results-based management among partners must be strengthened; reporting should be based on results.

- More focused activities are needed to promote the health interests, information needs and rights of youth among parents, men, religious leaders and other gate-keepers of tradition.

- Prospects for future funding need to be made explicit to IPs at the outset of planning cycles to avoid unnecessary downsizing of interventions. This should be done even as plans are being developed, as this helps in the prioritisation of activities.

- The immediate objectives of projects within the 7th CP should be realistic in terms of what can actually be achieved, given historical, socio-cultural, religious and local contexts, and the timeframe in which the activities are going to be implemented. An approach that explicitly combines short-term practical projects with long-term strategic social outreach is recommended. Defining such objectives in a participatory manner with implementation partners and with youth input may be especially fruitful.

- UNFPA is being strongly encouraged to consider a combination of factors before expanding the partner base, specifically issues of resource sufficiency, the effects of expansion on programme impacts against available resources, and comparative advantages that new partners would bring beyond what existing partners can offer. Current funding levels for partners are meagre and adding new partners may affect the degree of impact that can be realised from interventions.

- The expansion drive for focus districts by intervention partners must be critically considered before being implemented. For instance, MAGGA operates in six districts with funding from UNFPA. Funding fluctuates between 150,000 USD and 180,000 USD, which may not be adequate to produce tangible impacts if overstretched.

- The CO is being commended and encouraged to continue its leadership on various issues of national importance, such as the 50/50 campaign, PHC, population and SRH policy development and resource mobilisation efforts, which significantly contribute to improving quality of life for Malawians.
• Continuous financial support should be provided for capacity building of IPs to further enhance programming, financial management capacities and overall organisational capabilities; these must be strengthened in order to achieve sustainability. In the next CP, organisational development should also constitute strategies for each of the outcome areas so as to increase effectiveness.

• The UNFPA/CO should sustain resource mobilisation efforts, preferably by developing a formal resource mobilisation strategy involving partners.

• A formal capacity needs assessment for IPs must be conducted prior to the commencement of the 7th CP to inform the development of capacity intervention strategies.

• The government, other IPs and UNFPA should engage in volunteer retention improvement strategies for the next CP to reduce the high attrition rate among volunteers, as it affects the continuity and sustainability of interventions.

9.2.2 Programme Management

• Strengthen the capacity of the MoDPC to effectively coordinate the current and next CP. A key will be to increase the number of professional staff. In addition undertake to strengthen capacities of IPs based on the capacity assessment (due diligence) that was recently undertaken. If capacity was not explicitly defined then commission a study on Capacity Assessment as well as Capacity Strategy Development process for the IPS. This would help to unearth the specific capacity requirements for the IPs and would guide a capacity development drive for the IPs. The enhancement of capacity within IPs would be appropriate for increasing effectiveness which would in turn increase quality of services, impacts as well as sustainability.

• Formulate a resource mobilisation strategy to augment the financial resources provided by UNFPA. Though more resources were raised than anticipated, with an explicit resource mobilisation strategy, a systematic and coordinated effort to raise resources is likely to be more successful. The private sector in the country is a potential source of funds.

• The UNFPA, CO and government should move rapidly to develop the next CPAP in order to secure resources for timely implementation in the next cycle (2012–2017).

• Introduce semi-annual programme review meetings with partners, along with quarterly review meetings among partners within the same outcome areas to monitor and evaluate progress, and promote sharing of experiences, learning and teamwork among implementing partners and CO staff.

9.2.3 Financial Management

• The CO should continue its support of resource mobilisation efforts based on an “inward-looking” strategy.

• Provide continuous financial support for capacity building of IPs to further enhance programming and financial management capacities and minimise negative effects of staff attrition.
• Conduct a capacity assessment of the IPs (including the government), and engage them in an exercise to systematically increase capacity for programme budgeting and reporting.
• The government, other IPs and UNFPA should engage in a staff retention improvement strategy for the next CP.
• Strengthen capacity of IPs in financial systems enhancement to sustain and increase financial accountability as well as timely reconciliation and reporting.

9.2.4 Programme Performance

Reproductive health

• Support abstinence programmes among girls discouraging sex before marriage.
• Promote the empowerment of young women and girls with economic and livelihood interventions to increase self-reliance, which will reduce intergenerational sexual relationships for economic gains.
• Promote peer education activities with incentives, as some risky behaviours among girls and young women are a result of peer pressure.
• Support male role modelling interventions and encourage exchange programmes to promote the participation of men in reproductive health issues.
• Ensure the targeted training of nurses and medical personnel in focus areas for the program.
• Promote community conversation programmes in which communities should be actively engaged in discussions around reproductive health so that community-based solutions may be identified and encouraged.
• In the 7th CP, efforts need to be made to support interventions with proposed sustainability plans.
• Strengthen and support the SRH unit to develop a strategic plan with SRH partners in government, NGO, CBO and FBO sectors to ensure a targeted and coordinated response to implementing SRH activities. Decentralisation to regional coordination is also recommended.
• There is a need to improve the provision of essential/basic RH equipment and supplies in the health centres.
• Community awareness has increased behaviour changes, such that more women are realising the importance of FANC and hospital delivery. Due to long distances between homes and hospitals, most women await labour at the waiting shelters, which are congested. Planning for the construction of more waiting shelters in selected health centres should be considered.
• Community involvement is a key to mobilising communities to participate in the reduction of maternal and neonatal deaths. Therefore, there is a need to intensify community refresher trainings for different committees like task forces, safe motherhood and VHCs,
and community workers like CBDAs. Strengthening community based health service provision is key for reaching out to as many poor people as possible so as to meet their needs for services. In additional this approach is also fundamental for ensuring sustainability of services and benefits.

- Promote and intensify regular supervisory visits to health centres to maintain service quality and for mentoring and coaching purposes.

- HSAs have been central in the delivery of SRH services at the grassroots level. However these are in short supply and that some of them have not undergone appropriate basic training as yet due to lack of financial resources. Consider providing resources for the basic 8 weeks training of the HSAs so as to increase skill base, quality of SRH services.

- Work with RHU to lobby mainstream MoH as well as Ministry of Finance and Department of Human Resources Management Services to provide for the recruitment of more HSAs who would be deployed across the country. UNFPA could in this context argue that it would cater for the training of the HSAs.

**HIV prevention**

- Continue promoting HTC before marriage among young women and girls.
- Establish support groups for PLHIV.
- Continuously conduct assessments of appropriate delivery methods for SRH/HIV interventions to enable the development of innovative approaches to reaching youth and young women.

**Population and development**

- Continue to strengthen the capacity of appropriate staff at NSO by improving their skills in targeted population issues.
- Continue to strengthen capacity of the MoDPC to effectively implement the upcoming National Population Policy and to help them, in turn, effectively build capacity of local authorities and other strategic CSOs in processing and analysing population data.
- Support the development and implementation of a clear national research agenda on population and development issues which must be implemented with CSOs, the MoDPC and the University of Malawi to inculcate the utilisation of population data in the country.
- Promote the engagement of final year population students at Chancellor College in debates and public lectures on population issues to help build their capacities and prepare them for professional work in population development.
- Support the NSO to further develop the MASED website to make it more interactive and enable the anchors of the site to receive feedback and monitor its utilisation.
• Hold regional meetings for research institutions, CSOs and consulting firms to educate them about the MASEDA and foster its utilisation.

• Develop more innovative interventions that will promote the integration of population variables in development planning at all times.

**Gender**

• Support scaling up and greater coordination of civil society initiatives to address GBV issues, and in particular, advocate for the participation of communities and community representatives in policy, planning and implementation.

• The media is a potentially powerful vehicle for disseminating gender and GBV prevention information and knowledge. UNFPA should support the media and/or promote the engagement of media managers to overcome institutionalised gender biases and develop gender-sensitive messages.

• UNFPA should consider supporting the establishment of a network for other public sectors to spearhead the lobbying for gender-sensitive budget formulation in these sectors.

• UNFPA should continue to support awareness and capacity building of duty bearers in terms of gender-related laws.

• There is a need for implementation partners to link their annual work plans to the CPAP to ensure proper monitoring of output achievements in the CPAP.

• UNFPA should set specific targets for each of the implementation partners that will contribute to the achievement of the targets outlined in CPAP monitoring tool.

• Lack of rehabilitation services for GBV victims has left some victims at the mercy of their abusers due to a lack of skills for economic independence. UNFPA should therefore consider financing capacity building activities for GBV victims that will enable them to acquire skills that will help them engage in different vocational activities.

• Promote and support civic education and awareness for men on the perils and dangers of GBV and the consequences of continued perpetration.

• Strengthen the effectiveness of community groups such as CAGs by providing resources such as bicycles to facilitate mobility to meetings and community-level monitoring processes.

• The institutionalisation of men combating GBV should be strengthened and possibly expanded to other districts to ensure enhanced behavioural change among male GBV perpetrators.

• Consider promoting small-scale enterprise intervention and or small-scale commercial farming operations such as goat production, piggery and poultry production among IPs to economically empower survivors/victims of GBV and the vulnerable, especially females. These should be assisted with financial capital or in-kind resources to start these initiatives after being comprehensively equipped with business skills. A regional organisation may be
identified to work in critically affected districts in each of the regions on a pilot basis after which a scaling up exercise could be planned.

- Support community dialogue programmes facilitating engagement in different discussions on specific GBV issues or harmful sexual cultural practices that form a platform for perpetrating GBV. Such conversations should therefore be aimed at unearthing those issues and finding solutions at community levels on how to address them. In so doing, communities will become part of a local solution to combating GBV.

**Final Recommendations for Future Evaluation**

- It is critical that the 7th CP begin with very specific, measurable and achievable objectives for which baseline data must be made available by the implementing partners within the first six months of the start of the project. These baseline objectives will become benchmarks against which the recommended semi-annual reviews be measured.

- Even though UNFPA evaluation guidelines recommend six to eight weeks to complete the end of CP evaluation, we believe that eight weeks should be the minimum time allowed. We undertook this evaluation in four weeks, including only one week of field work. There was not enough time to conduct follow-up visits to clarify comments. Additionally, there was not enough time to follow-up on some of the suggestions for clarifications made at the feedback workshop that was held for this exercise. A lot more time is needed to ensure that UNFPA collects as much information as possible on its programmatic investment so that subsequent plans can focus on achieved goals and gaps to be bridged while identifying which partners are in the best positions to fill those gaps.
10 APPENDICES

10.1 References

References

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- Final Report Malawi 6th Country Program Mid Term Evaluation
- SRH Policy
- UNFPA/IPPF-Family Planning Association of Malawi-Annual Report 2009
- DRCS 2009:Mapping of Stakeholders on Gender Based Violence in Malawi Final Report
- Maputo Plan of Action
- GoM/MoH: Essential Health Care Package
- Malawi 2010 BEmONC Assessment Draft Assessment Report
- Roadmap for Reproductive Health Services
- SADC: Protocol on Gender and Development
- Annual work plans and progress reports for the various programme implementers and UNFPA CO for the period 2008-2010
List of People and Organisations Consulted

<table>
<thead>
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<td>Medical Assistant</td>
<td>Mzenga</td>
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FGDs In Nkatabay: CBDA, ADC, Peer educator, VHC, Taskforce for self motherhood, TBAs and youths

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<td>Nurse</td>
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<tr>
<td>Village Headwoman</td>
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FGDs in Mchinji: VHC, Safemotherhood taskforce, CBDA and the youth

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FGDs in Karonga: Guiders, Peer educators, Counsellors, Condom users, PLHIVs, and VHC

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FGDs in Mangochi: VHC, HCAT, ADC, Chisope Community Action Group, Mkumba Community Action Group, Mkambiri Community Action Group

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10.2 Data Collection Instruments

UNITED NATIONS POPULATION FUND (UNFPA)

END OF THE 6TH UNFPA COUNTRY PROGRAMME EVALUATION IN MALAWI

UNFPA STAFF IDI GUIDE

Name(s) of Interviewee(s): ____________________________________________

Designation: __________________________________________________________

Date: _________________________________________________________________

Sex: ___________________________________________________________________

Section A: Background Information and General Issues

1. Duration of employment, academic and professional attainments and experience
2. Responsibilities of the staff member in the organization and how does he/she contribute to the implementation of 6th CP
3. What constituted the major findings of the situation analysis that guided the design of the 6th CP?
4. How did these findings inform the design of the program and how was the program aligned to UNDAF, MGDS, MGDs and ICPD?
5. Would you consider the alignment to have been adequate in particularly contributing towards improved livelihoods of the people of Malawi? please explain.
6. What would you consider to be the major activities that were implemented within your thematic outcome area? Please allow respondent to list various activities.

Section B: Institutional Arrangements

7. What is your organizational structure and how does this support the implementation of the 6th CP?
8. How adequate, effective and relevant is this structure in relation to skills and personnel numbers and general capacities?

9. How do various entities within the structure interface with your implementing partners?

10. What linkages exist between UNFPA, other UN agencies, development partners, NGOs and Government departments? To what extent does your approach to service delivery provide for greater collaboration and participation with these stakeholders to foster concerted efforts, complementarities and sustainability?

Section C: Program Relevance

11. How has the implementation 6th Country Program contributed to the achievement of MGDS priorities as well as MDGs and improved the current health and social indicators of the people of Malawi?

12. To what extent have your interventions as per the design of the 6th CP responded to the needs of your various target communities and beneficiaries in relation with the baseline/situation analysis?

13. How has the 6th CP interventions addressed the needs and priorities of various communities/people in relation to access and utilization of reproductive health services, HIV prevention, Population and development and Gender equality?

14. How has the implementation of various interventions through the 6th Country program contributed to improving reproductive health of the following categories of people in general as well as among your target communities in accordance with the baseline situation as well as in relation with RH national policy and the road map?
   a. men,
   b. women and
   c. young people

15. How has the 6th CP facilitated the building of capacities for population and development experts to improve on usage of population data in policy development, programming and implementation of development programs?

16. To what extent has targeting of various people based on population data and distribution improved as a result of improved capacity of relevant experts?

17. To what extent do you think curbing gender based violence (GBV) and enhancing women’s empowerment

18. To what extent has the implementation of HIV related interventions contributed to the HIV and AIDS response in relation to the following (in case of hospitals obtain district data on trend of HIV and AIDS indicators over the period of the CP)
   a. Prevention and behavioral change?
   b. Treatment, care and support and impact mitigation
   c. Impact mitigation
• How did your UNFPA funded interventions affect the following emerging issues:
  1. Provision of DMPA at community level by HSAs
  2. Change in policy for health center staff to provide LTPM
  3. Change of the role of TBAs
  4. Revitalization of CBDAs
• How did the program respond to these emerging issues?
• How do you think these developments influenced the project outcomes and outputs? How did the relevance of the project goals change during the implementing period?
• How feasible was it to achieve the expected outcomes against the following context: program timeframe, capacities and resources available?
• In planning your interventions, do you take into account human rights principles and standards and how are these promoted?
• Which activities that you have been implementing through UNFPA would you consider replicating elsewhere and or scaling up given an opportunity to do so?
• In your own assessment, do you think that priorities, interventions and issues implemented through the UNFPA are still relevant given the current national situation, please explain?
  19. Which districts do you carry out your interventions
  20. Describe your target groups and beneficiaries for your interventions?
  21. How long have you been in partnership with UNFPA?
  22. What is the major mandate of the institution?
  23. What priority area of the UNDAF does the institution address?
  24. How and why was the 6th Country programme conceived?
  25. What major areas of the MGDS and MDGs was the 6th CP asset to address?
  26. How relevant is the 6th CP to UNDAF outcomes. MGDS themes and the MDGs?
  28. Is the CP contributing to the achievement of the UNDAF and NGDS? How?
  29. How relevant are the CP outcomes to the current national situation in terms of improving RH of the men, women, and the youth in accordance to the ICPD?
  30. How relevant and effective are the CP HIV prevention activities in contributing towards national response to HIV prevention?

6th CP Implementation
31. How relevant and effective are the gender activities in relation to contributing towards the national response to combating GBV?

32. What has UNFPA as an institution done to support the achievement of the NRHIV Prevention and National Response to Combat GBV action plans?

33. Were the outcomes set to be achieved realistic to the needs and priorities of the people of Malawi?

34. Has the CP achieved the objectives? What factors contributed to/hindered to the achievement of the objectives?

**CP Implementing Partners**

35. How does UNFPA select its implementing partners?

36. What are the specific programme areas the IPs implement in each of the 4 major implementation areas of RH, HIV prevention, Gender and Population and Development?

37. How does the UNFPA monitor programme implementation by partners as well as the capacity of the partners to implement the programme?

38. Are there any linkages between your M&E systems and that of the IPs?

39. Does the UNFPA provide capacity building support to the IPs and how has this assisted in meeting the targets of the CP?

40. How effective are the IPs programme activities in contributing to achieving the CP’s outcomes?

41. What evidence is there on the effectiveness of the activities and the program as a whole in addressing the needs of the beneficiaries and contributing to the achievement of the MGDS?

**Sustainability and Impact**

42. What sustainability measures were embedded in the CP development?

43. Have these measures been ably implemented by the IPs?

44. How have the IPs involved the beneficiaries in implementing these measures?
45. In your own opinion, what has been the positive and negative impact of the programme on the people and the nation as a whole?

**Achievements and Challenges**

46. What are the achievements of the CP based on each of the outcome area?
47. What are the challenges/constraints encountered in the course of the program that affected the achievement of the objectives of the programme? Explain challenges in the context of political, socio-economic, cultural and technological.
48. What would you consider as major areas that need improvement in order to inform the successful and realistic development of the 7th CP?
49. Were there any emerging issues that came out in the course of the programme and how did they impact on the achievement of the outcomes?

**Lessons Learnt**

50. What are the lessons learnt in the course of the programme implementation?
51. What do you think would be the potential opportunities and threat in implementing the 7th CP based on the lessons learnt?
52. What practices would you recommend to be replicated or left out in subsequent Country Programmes?
UNIVERSITY OF MALAWI

END OF THE 6TH UNFPA COUNTRY PROGRAMME EVALUATION IN MALAWI

IDI GUIDE FOR REPRODUCTIVE HEALTH PARTNERS

Please provide background to the exercise

Collect information on the following

Date of interview Name of Interviewee
Designation Name of Partner Location of partner

Section A: Background & General Issues

1. What are you areas of interventions in relation to UNFPA funded programs and describe the areas of your partnership in relation to the following

   o Financial assistance
   o Technical assistance
   o Capacity building

2. Which districts do you carry out your interventions

3. Describe your target groups and beneficiaries for your interventions?

Section B: Program Effectiveness:

4. How would you describe the extent to which you have achieved your UNFPA funded programmatic objectives, expected results and their expected targets as outlined in your in your design and annual plans?

5. What do you consider to be the key factors that:

   o Contributed towards the achievement of you objectives and expected results
   o Constrained the effective achievement of the objectives?

6. What mechanisms were put in place for tracking and documenting any lessons that were learnt in the course of the program?

7. What would you consider as the major lessons that learned and how did you use such lessons in management decision making process? Please elaborate

8. What would you consider to be some of the promising practices that could be expanded in the next phase of your partnership with UNFPA or in the next country program?

9. How did management and operational procedures as stipulated in the CPAP including execution arrangements, coordination, monitoring and human resources influence your management and implementation processes of UNFPA funded program?
10. What mechanisms did you put in place to align your management and implementation practices with UNFPA management and implementation operational procedures and how has your organization been positively or negatively impacted in the same regard?

11. What were the major challenges that you encountered in implementing UNFPA Malawi funded programs?
12. What would you consider to be some viable solutions to such challenges?
13. What are some of the strengths for UNFPA that puts it at a comparative advantage that could form vital areas that could be focused on in the upcoming 7th CP by the Country Office in the context of MGDS and UNDAF?

### Section C: Program Efficiency

14. How much resources were planned for the implementation of UNFPA funded intervention and were all such resources made available to achieve projected outputs and outcomes?
15. How adequate were the resources planned for UNFPA funded interventions and were planned outcomes attained with the provided recourses and were they timely released?
16. Apart from UNFPA resources, what other locally generated resources are used for implementing your interventions?

### Section D: Program Sustainability

17. What mechanisms were put in place through the 6th CP to promote sustainability of activities that are being supported in the community?
18. To what extent did communities participate in planning, implementation and monitoring of UNFPA funded interventions and to what degree did this foster ownership of the interventions among communities? Please obtain meaningful evidence
19. What efforts were made to improve your technical and management/leadership skills as well as financial resource mobilization for purposes of institutional sustainability

### Section E: Program Impact

20. How have the UNFPA funded interventions that you have been implementing impacted on the lives of your target groups and wider communities in relation to reproductive health and HIV and AIDS as well as you as an organisation?
21. What would you consider to be the negative effects of interventions through the 6th CP on communities and your target groups?
22. How has the health indicator improved since the program stated its implementation (MMR, CYP, NMR, IMR, HIV Prevalence. Rate, number of AN visits, PMTCT clients, hospital deliveries)
23. What would you recommend as issues that need to be considered when developing 2012 to 2016 Country Program in the context of the MGDS and UNDAF?
Section F: Monitoring and Evaluation

24. What monitoring system do you have in place for your programs and what tools do you use for data collection?
25. How do your data /indicators feed into the overall CP monitoring plan?
26. How do you report UNFPA funded programs and what specific indicators do you monitor?
27. To what extent was the M&E designed for program able to track the outputs of the program and outcomes?

UNITED NATIONS POPULATION FUND (UNFPA)

END OF THE 6TH UNFPA COUNTRY PROGRAMME EVALUATION IN MALAWI

FOCUS GROUP DISCUSSION GUIDE FOR BENEFICIARIES

Number of Participants

Date

Males: Females:

Section A: Background Information and General Issues

1. What activities are you involved in and which organization/program supports you in those activities?
2. What type of support/benefit do you get from the organization/s?

Section B: Reproductive Health

3. What services are available in your community in regards to Reproductive? Who is providing these services? Probe: For young people?
4. How has access and availability of services such as family planning, Obstetric Fistula and BEmONC improved in this area? Probe: For young people?
5. How have these service on RH impacted on your lives in terms of the following among other aspects:
   a. reduction of maternal mortality
   b. Reduction of infant and neonatal mortality
   c. Increased access to family planning contraceptives leading to manageable family sizes
**Section C: HIV & AIDS Prevention**

6. What services are provided on HIV prevention?

7. To what extent has the implementation of HIV related interventions contributed to the following among people in this community? *(triangulate responses with facts and statistics from DHO)*
   - Transformed preventive practices
   - Change in sexual behavioral change
   - Reduced Multiple and Concurrent Partnerships
   - Increased use of condom
   - Reduced cases of chronic and AIDS related sicknesses
   - Increase community based care and support services
   - Increased community participation in care for OVCs and vulnerable groups

8. What other services on RH and HIV and AIDS do you require in this area?

9. How relevant are the type of services/activities implemented by your partner organization through UNFPA to your needs and priorities?

**Section D: GENDER**

10. What services are provided that foster equality between males and females?
   a. Give an example

11. How have such services contributed to improvement access to productive resources and economic situation among women as well as shared roles and responsibilities between males and females?

12. What services are provided on the following:
   a. reducing Gender Based Violence (GBV)
   b. mitigating the impact of gender based violence among victims as well as perpetrators
   c. rehabilitating victims

13. How have various services on GBV led to the following:
   a. Increased reporting of GBV
   b. Improved management of small scale businesses due to acquisition of new skills
   c. Reduced cases of GBV due to behavioural and attitudinal changes

14. What other services do you require on gender/GBV issues?
15. Any other comments you would like to offer on this topic?

10.3 Terms of Reference

End of UNFPA 6th Country Programme Evaluation in Malawi

1. Background and Context

The Government of Malawi/United National Population Fund (UNFPA) 6th Country Programme and Country Programme Action Plan (CPAP) which is being run over four years (2008-2011) focuses on Reproductive Health and HIV Prevention, Gender and Population and Development. The goal of the 6th Country Programme is to contribute to the improvement of quality of life of the people of Malawi through improvement in reproductive health status, prevention of HIV, increased gender equality and women empowerment and favourable interactions between population dynamics and development. The Programme is aligned to the outcomes of the United Nations Development Assistance Framework (UNDAF), the Malawi Growth and Development Strategy (MGDS) and to the fulfilment of International Conference on Population and Development (ICPD) Programme of Action. Its components include; Reproductive health and HIV Prevention, Gender, and Population and Development. These components mainstream advocacy and a rights based and culturally sensitive approach.

The expected outcomes on the 6th country Programme are:

- Equitable access to reproductive Health and HIV prevention service increased
- National capacity to use population data for policies and programme formulation, management and monitoring improved
- Gender equality and women’s empowerment enhanced by 2011

The country Programme outcomes directly contribute to the achievement of specific UNDAF outcomes. The country programme will be assessed through the achievement of set targets for each programme area. Several outputs and strategies as specified in the CPAP have been proposed for the realisation of the country programme outcomes.

UNFPA Malawi is working with the Government of Malawi through the Ministries of Finance, Economic Planning and Development, Health, Education, Gender, Women and Child Development, Youth Development and Sports, the National Statistical Office, national AIDS Council (NAC) and the University of Malawi. UNFPA is also working with the Civil Society Organisations including Faith Based Organisations. The NGO’s that UNFPA works with are; Banja La Mtsogolo (BLM), Family Planning Association of Malawi (FPAM), NGO gender Coordination Network, Malawi Interfaith AIDS Association (MIIA), Coalition of Women Living with HIV and AIDS (COWLHA) and Malawi Girl Guides Association (MAGGA) as some of its strategic partners for achieving the UNDAF and Country Programme outcomes.

UNFPA would like to evaluate the Country Programme during this penultimate year of closure so that the findings/recommendations inform the development of the next Country Programme in 2011.

2. Evaluation Purpose
The focus of the evaluation will be on the performance and impact of the 6th country programme, paying particular attention to Reproductive Health and HIV Prevention, gender and Population and Development. The consultant(s) should determine the relevance, effectiveness, efficiency, impact and cost effectiveness in the light of the objectives specified in the country programme. As part of the final report, the consultant(s) will also develop a set of recommendations for future programming on how to address any adverse impacts or to optimise programme benefits.

The specific evaluation objectives are to:

- Assess how the current Country Programme has contributed to the achievement of UNDAF, MGDS outcomes and the MDGs.
- Assess the effectiveness of the 6th country Programme in improving reproductive health of men, women and young people in Malawi.
- Assess the effectiveness of the 6th country Programme in improving the availability of good quality, sex disaggregated data and increasing its use in development.
- Analyse the contribution of the 6th country programme towards the national response to HIV prevention.
- Assess the effectiveness of the 6th Country programme in curbing gender based violence (GBV) and enhancing women’s empowerment.
- Assess the sustainability of the country programme interventions.

**Evaluation scope and focus**

The evaluation will focus on the implementation and impact of the 6th country Programme 2008-2011. It will specifically answer the key evaluations questions below:

**Key evaluation questions**

**Relevance**

Has the country Programme addressed the needs and priorities of the people of Malawi in relation to access and utilisation of reproductive health services, HIV prevention, Population and development and Gender equality? Did the Programme focus on the most critical issues related to the promotion of ICDP agenda?

Did the objectives and interventions of the programme address priority needs of the target population? Did those needs evolve over the course of the programme? If new needs emerged, was the programme responsive to those needs? Was the programmes beneficiaries targeting appropriate given the context? Are there gaps in service, in terms of availability and/or quality that still need to be filled?

Which activities being implemented in the 6th country Programme could be replicated and or scaled up in other areas? Are the issues that the CP was set to address still relevant in the current situation?

**Effectiveness**

To what extent were the programme objectives, expected results and their expected targets met under the 6th country programme? What key factors contributed towards the achievement of these objectives and expected results, and what factors hindered this? How effective did the
programme staffs coordinates with other relevant agencies (e.g. government, UN Agencies, NGOs or community based organisations) in the programme areas? To what extent were the lessons learned documented and used to modify the programme?

What are the promising practices that can be expanded in the next country programme?

To what extent was the M&E designed able to track the outputs of the programme? Did the CP implementation adhere to the programme management and operational procedures as stipulated in the CPAP including execution arrangements, coordination, monitoring and human resources?

**Efficiency**

What measures did the 6th country programme put in place to improve cost efficiency of its Programme and what is the effect? What did the country Programme do to improve accountability, transparency and risk management and what was the effect? What measures have been taken during planning and implementation to ensure that the resources are efficiently used? Could the Programme have been implemented with fewer resources without reducing the quality and quantity of the results?

How did the formal decision making processes contribute to or hinder the efficiency and effectiveness of the programme? Describe the strengths and weaknesses of the management structure as it relates to the programme.

**Sustainability**

How is the country programme promoting sustainability of activities that are being supported in the community? What evidence is available for sustainability of such programmes: How effective are the sustainability measures so far? Are there any sustainable and replicable practices to be documented under the 6th CP?

**Impact**

What impact is the 6th CP having on the lives of the people of Malawi in terms of reproductive health, HIV prevention and AIDS, Gender equality and population and development issues? According to the beneficiaries, what were the main impacts of the programme, both positive and negative for the three main programmes? How has the CP interventions impacted the lives of the vulnerable groups?

**Evaluation Approach**

The evaluation will be conducted using the following approaches:

- Developing an evaluation framework sand methodology; and refining these with the programme/evaluation team.
- Developing the evaluation plan
- Conducting a desk review of UNDAF, CP, CPAP, progress reports. Annual reports by implementing partners, financial reports by implementing partners and programme evaluations, MGDS progress reports, SWAP/Health Sector review reports, reports of the SWH-TWG

71
• Participating in briefing meetings with UNFPA staff (and other stakeholders)
• Conducting key informant interviews and in-depth interviews with UNFPA staff and partners of the 6th CP.
• Conducting Focus group Discussions
• Conducting field visits to selected programme sites to observe activities
• And any other relevant methodology

The evaluation team will develop an inception report which will provide details on the approaches and methodologies to be followed. The inception report will be presented to Country Representative for approval before the start of the evaluation. The inception report should provide among other things the following:

• Further refinement of evaluation questions
• An indicator Framework for evaluating the 6th country program
• Details of data collection instruments to be used during the evaluation
• Proposed schedule of partner visits
• A schedule of detailed outputs (deliverables) and dates in line with work Programme scheduled below.

Management and Support arrangements

The evaluation will be executed by UNFPA. The consultant (s) will be expected to work in close collaboration with all the implementing partners of the 6th CP and potential stakeholders. The consultant (s) will report to the Country Representative through the Deputy Representative (Programmes Coordinator). UNFPA Malawi country office will assist the consultant (s) with appointments to meet partners for interviews. The country office will also provide the necessary logistical and administrative support to enable the consultant(s) to carry out this assignment.

Evaluation and Team Composition

The evaluation is expected to be conducted by two consultants, one international and one national. The successful candidates should have at least a Masters degree in Public health, Social Sciences or Development Studies; with at least five years experience in carrying out evaluations for national and/or international and bilateral institutions. The Consultant should have a good knowledge in M & E. They should also have sound knowledge of Reproductive health, HIV and AIDS and Gender issues.

The following specific selection criteria will be used to select the consultant (s).

1. Knowledge of reproductive health issues including HIV and AIDS.
2. Evaluation methods and data collection skills.
3. Experience in carrying out CO evaluations.
4. Process management skills.
5. Excellent communication and report writing skills in English.

**Deliverables**

- An inception report demonstrating understanding of the assignment within one week from the start of the assignment.
- An evaluation design methodology that satisfactorily demonstrate how the 6th CP will be assessed.
- A time table for the evaluation exercise
- Tools for the evaluation exercise
- A well written midterm evaluation addressing the objectives of the assignment (format to be provided)